NO. 160. AN ACT RELATING TO THE COORDINATION, FINANCING AND DISTRIBUTION OF LONG-TERM CARE SERVICES.

(H.782)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. DEFINITIONS

For the purposes of this act,

(1) Agency means the agency of human services.

(2) Long-term care services means the range of services, other than acute care services that provide time-limited curative or restorative treatment, that are delivered in the home, community or an institution to people with functional or cognitive limitations and require assistance with performing activities of daily living and include services provided in a nursing home or in an individual's home by a nurse, health aide or personal attendant.

Sec. 2. REDISTRIBUTION OF LONG-TERM CARE EXPENDITURES

(a) By the end of fiscal year 1997, the agency shall reduce Medicaid nursing home expenditures by an amount computed by multiplying 46 beds by the average annual expenditure for a nursing home bed in fiscal year 1997, as determined by the division of rate setting. For fiscal years 1998 through 2000, the agency, in cooperation with the nursing home industry and other affected parties, may reduce Medicaid nursing home expenditures in each fiscal year by an amount computed by multiplying the number of beds for that fiscal year, as indicated in the following schedule, by the average annual expenditure for a nursing home bed for that fiscal year, as determined by the division of rate setting, provided that, at the end of fiscal year 2000, the agency shall have reduced the Medicaid nursing home expenditures by the total amount of the reductions scheduled for each fiscal year, 1997 through 2000.

FY 1998 68 beds

FY 1999 59 beds

FY 2000 61 beds

(b) If the Secretary determines that it is necessary to reduce the number of nursing home beds in fiscal year 1997 in order to reduce nursing home expenditures pursuantto subsection (a) of this section, the Secretary shall develop a plan that assures that the supply and distribution of long-term care services are not diminished in any community in which one or more nursing home beds may be eliminated. This plan shall be submitted to the House and Senate Committees on Health and Welfare not later than January 1, 1997. No nursing home beds may be eliminated by the Secretary until February 1, 1997.

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The requirements of this subsection shall not impede the Secretary's authority to reduce nursing home expenditures effective July 1, 1996, pursuant to subsection (a) of this section and to redirect those expenditures to fund home and community-based services pursuant to subsection (d) of this section.

(c) The reductions required in subsection (a) of this section shall not have the effect of:

(1) diminishing or reducing the quality of services available to nursing home residents; or

(2) forcing any nursing home resident to involuntarily accept home and community-based services in lieu of nursing home services; or

(3) causing any nursing home resident to be involuntarily transferred or discharged as the result of a change in the resident's method of payment for nursing home services or exhaustion of the resident's personal financial resources.

(d) The reductions required in subsection (a) of this section shall be redirected in fiscal year 1997 to home and community-based services. For fiscal year 1998 and thereafter, the reductions required in subsection (a) of this section shall be redirected in that fiscal year to fund both home and community-based services and any programs designed to reduce the number of nursing home beds. Any general funds that are redirected but not spent during any fiscal year shall be transferred to the long-term care special administration fund which is hereby created. Notwithstanding the provisions of 33 V.S.A. § 588(3), interest earned on the fund shall be retained in the fund. All monies received from or generated to the fund shall be expended only for home and community-based services or for mechanisms that reduce the number of nursing home beds. The fund shall be managed and disbursements made in accordance with the provisions of subchapter 5 of chapter 7 of Title 32. For the purposes of this act, A home and community-based services means long-term care services that are designed to assist older Vermonters and people with disabilities to remain independent and avoid inappropriate institutionalization. Home and community-based services include:

(1) Home and community-based waiver.

(2) Traumatic brain injury waiver.

(3) Residential care homes.

(4) Attendant services program.

(5) Homemaker services program.

(6) Older Americans Act funds.

(7) Adult day services and home health expenditures for long-term care.

(8) Vermont independence fund.

(9) A pilot project to recruit and train volunteer respite care providers to provide support to family caregivers of individuals who have Alzheimer's disease or related disorders and live in rural areas of the state.

(10) Any other long-term care support services available.

(e) The long-term care funds generated by the reductions in nursing home expenditures required in subsection (a) of this section shall be distributed among the following categories of consumers:

(1) Nursing home residents who desire transfer to a home and community-based setting and for whom such transfer is medically appropriate and cost effective.

(2) People on waiting lists for publicly funded programs as of July 1, 1996, and at the highest risk of nursing home placement.

(3) People at the highest risk of nursing home admission.

(4) People with the greatest social and economic need.

(f) Notwithstanding other provisions of this section and the provisions of chapter 61 of Title 33, up to $100,000.00 of the redirected funds in fiscal year 1997 shall be directed to the independence fund under subdivision (d)(8) of this section, to be used for grants which have matching funds equivalent to that of Medicaid and are consistent with the purposes of and the time frame of this act. Proposals shall be received by September 1, with recommendations submitted to the secretary within 30 days thereafter.

Sec. 3. IMPLEMENTATION

(a) The agency shall document and verify the amount of funding transferred from nursing home services to home and community-based services and any additional home and community-based services that are provided or enhanced from this transfer of funds. This documentation shall be submitted to the general assembly no later than January 1, 1997, and on each January 1, until January 1, 2000.

(b) The agency shall complete the following by July 1, 1997:

(1) Implement the initial phase of a comprehensive data system that tracks long-term care expenditures, services, consumer profiles and consumer preferences.

(2) Implement a system of statewide long-term care service coordination and case management to minimize administrative costs, improve access to services and minimize obstacles to the delivery of long-term care services to people in need. At a minimum, the system shall include:

(A) A request for proposal process by which the agency may authorize local entities to administer local long-term care services.

(B) A comprehensive assessment system by which all individuals shall be evaluated prior to receiving long-term care services and may be evaluated periodically, as needed, while long-term care services are being provided to ensure that the individual receives appropriate long-term care services.

(C) Coordination of all the long-term care services administered by the following departments within the agency of human services:

(i) The department of aging and disabilities.

(ii) The department of health.

(iii) The department of mental health and mental retardation.

(D) Complete consumer information about all the long-term care services that are available.

(E) Consumer participation and oversight at the state and local levels in the planning and delivery of long-term care services.

(F) Long-term care service models that are alternatives to nursing home models, provided that the alternative models are comparable in cost or more cost effective than the nursing home models which provide equivalent services. Any alternative long-term care service models shall be financially viable, cost effective, promote consumer independence, participation and noninstitutionalization and, when appropriate, consumer direction and may include one or a combination of services such as assisted living, adult foster care, attendant care and modifications of the residential care home system.

(G) Proposals for legislation to create alternative long-term care service models.

(3) In consultation with the nursing home industry, consumer advocates, consumers and other long-term service providers, propose and implement methods to contain costs and encourage the reduction of Medicaid nursing home expenditures. These methods may include:

(A) Maximizing Medicare billing to pay for nursing home care.

(B) Mechanisms to reduce the number of nursing home beds, including a schedule for those reductions and recommendations for various sources of funding for payments to nursing homes to reduce the number of licensed beds.

(C) Elimination or modification of state nursing home rules that do not advance the quality of patient care and are not cost effective.

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(D) Applications for exemption from federal nursing home regulations to improve the efficiency and reduce the cost and paperwork required to regulate the nursing home industry.

(E) Proposals for adoption of or changes in rules, subject to the certificate of need review, that permit:

(i) greater cooperation among long-term care providers in such areas as discharge planning and staff sharing during periods of transition;

(ii) greater cooperation between nursing homes and providers of home care, respite care, adult day care and other long-term care services;

(iii) the use of vacant nursing home beds as respite beds.

(F) Changes in the state Medicaid plan to permit Medicaid billing for community residential care homes.

(G) Strategies to provide alternative financing of long-term care services by shifting the balance of the financial responsibility for payment for long-term care services from public to private sources by promoting public-private partnerships and personal responsibility for long-term care. These strategies may include:

(i) Flexible use of reverse mortgages.

(ii) Private insurance coverage for long-term care.

(iii) Tax credits or employment programs such as medical savings accounts for long-term care.

(iv) Changes in Medicaid eligibility requirements that increase consumers' financial responsibility for their long-term care, such as revising the rules relating to the transfer of assets.

(v) Social insurance models.

(vi) Estate recovery options.

(vii) Methods to supplement and support family and community care giving.

(4) Design and implement a voucher program that permits appropriate consumers to direct, manage and pay for their home and community-based care services. The agency shall apply for any federal waivers required to implement this program. The cost of providing those services pursuant to the voucher program shall be limited to no more than 90 percent of the cost of providing similar services under the Medicaidprogram and shall be designed to provide:

(A) Program flexibility that permits consumers to design, manage and pay for their own long-term care services, including hiring and firing their personal care assistants. The agency shall apply for available foundation grants to address barriers to recruitment and retention of caregivers. Policy and fiscal program design shall be based on input from consumers and caregivers to the Attendant Services Program Eligibility Committee, which shall include consumers, family members, service providers, advocates and agency personnel. Support services, such as transportation, training, and personal assistance reimbursement shall be provided to ensure such participation.

(B) Mechanisms to assure quality of service.

(C) An eligibility procedure by which appropriate long-term care service needs are determined for each consumer by means of a self-evaluation of needs and abilities in combination with an objective evaluation of the consumer's ability to direct, coordinate, and manage such services.

(D) The amount of any copayment to be made by the consumer, based on income criteria.

(E) A payment system by which a consumer receives a voucher in the amount required to pay for their long-term care services on a regular determined schedule.

The amount of the voucher shall not be more than 90 percent of the cost of providing the same or comparable services under Medicaid, less the amount of any copayment to be paid by the consumer.

(c) No later than January 1, 1997, the agency shall report to the general assembly regarding the progress made in complying with the requirements of subsection (b) of this section.

Sec. 4. LONG-TERM CARE BUDGET

By October 1, 1997, the agency shall submit to the general assembly a budget and budget management plan. The budget shall include all publicly financed long-term care services available to older Vermonters and people with disabilities including:

(1) Medicaid expenditures for nursing homes.

(2) Home and community-based waiver.

(3) Traumatic brain injury waiver.

(4) Residential care home waiver.

(5) Attendant services program.

(6) Homemaker program.

(7) Older Americans Act funds.

(8) Adult day services and home health expenditures for long-term care.

(9) Vermont independence fund.

(10) A pilot project to recruit and train volunteer respite care providers to provide support to family caregivers of individuals who have Alzheimer's disease or related disorders and live in rural areas of the state.

(11) Any other long-term care services.

Sec. 5. LONG-TERM CARE OVERSIGHT REPORTS

The Secretary of the Agency of Human Services shall review and report on the development and implementation of this act and on the agency's progress in complying with its requirements to the Committees on Health and Welfare of the House and the Senate. These reports shall be made at least semiannually, and the Committees on Health and Welfare are authorized to meet jointly no more than four times annually until July 1, 1998 to receive the report of the Secretary and to review the progress of the coordination, financing and distribution of long-term care services under this act.

In addition, the Committees on Health and Welfare shall solicit input from service providers and consumer representatives regarding the agency's progress in implementing the provisions of this act.

Sec. 6. VERMONT COUNCIL FOR FAMILIES OF CHILDREN WITH SIGNIFICANT DISABILITIES

(a) The Vermont policy council for families of children with disabilities is created and shall consist of at least 20 members to be appointed by the governor based on recommendations provided by the Vermont Developmental Disabilities Council, parent and family organizations and other organizations that represent the full range of disabilities.

(b) Members of the council shall include:

(1) Family members of children with significant disabilities or children with significant disabilities who are 18 to 21 years of age and represent the diversity and demographics within the state, including unserved and underserved populations. These members shall compose the majority of the council.

(2) Representatives from the departments of education, health, social and rehabilitation services, social welfare, budget and finance and mental health and mental retardation. These members shall have the authority to plan and implement policy within their

departments and, to the extent possible, shall be people with disabilities or members of families of people with disabilities.

(3) Any other members determined to be appropriate, including advocates and representatives of organizations for people with disabilities.

(c) Members of the council shall be appointed for staggered terms of three years, beginning April 1 of the year of appointment and shall serve until a successor is appointed. No member shall serve more than six years. Representatives of governmental entities may serve longer terms under unusual circumstances approved by the council. All funds appropriated under the Older Americans Act shall be expended in compliance with the provisions of the act.

(d) Members of the council shall elect a chair who shall be a family member of a child with a disability. No member shall vote on any matter that would provide direct financial benefit to that member or otherwise create an appearance of conflict of interest.

(e) The council shall perform the duties set forth in 20 U.S.C. § 1491f(e) of the Families of Children with Disabilities Support Act of 1994. The council shall alsocompile a list of all existing state boards that have similar or overlapping duties to those of the council and make recommendations for consolidation or termination of those boards to the general assembly no later than March 1, 1997.

(f) The agency of human services shall provide administrative support and any other support as required by the council.

(g) Members who are not state employees shall receive compensation pursuant to 32 V.S.A. § 1010.

Sec. 7. JOINT LEGISLATIVE STUDY COMMITTEE ON FAMILIES OF CHILDREN WITH DISABILITIES

(a) There is created a joint legislative study committee on families of children with disabilities, consisting of six members, one each from the Senate Committees on Appropriations, Health and Welfare, and Government Operations, to be appointed by the Senate Committee on Committees, and three members of the House, one each from the House Committees on Health and Welfare, Appropriations, and Government Operations, to be appointed by the Speaker of the House. The committee shall elect a chair from among its members, and have the assistance of the staff of the Legislative Council, the Agency of Human Services, the Department of Education, and any other appropriate state department or agency. The joint committee may meet during the adjournment of the General Assembly for no more than six meetings, and for attendance at such meetings members shall be entitled to compensation and reimbursement of expenses as provided in 2 V.S.A. § 406.

(b) The joint committee shall evaluate the types and extent of existing support services for families of children with disabilities, the administrative costs associated with each program, the percentage of funds provided directly to families and family support services, the eligibility criteria for families, and the number of families on waiting lists for these services. The committee shall evaluate and determine the feasibility of establishing, with existing funds, a family support program for families raising children with disabilities, and how current services could be provided in aneasily accessible, family-directed and cost effective manner. The committee shall make recommendations to the General Assembly no later than January 15, 1997.

Sec. 8. 18 V.S.A. § 9434(a)(4) is amended to read:

(a) No new institutional health service shall be offered or developed within this state by any person, without a determination of need and issuance of a certificate of need by the board, as provided in this subchapter. ANew institutional health service@ includes:

* * *

(4) a change from one licensing period to the next in the number of licensed beds of a health care facility through the addition or conversion, or through the relocation from one physical facility or site to another*[~~, of four beds or 10 percent, whichever is less, provided that a change exempted by this section may occur only once in a four-year period~~]*;

Sec. 9. 33 V.S.A. § 900 is added to read:

§ 900. DEFINITIONS

Unless otherwise required by the context, the words and phrases in this chapter shall be defined as follows:

(1) Agency@ means the agency of human services.

(2) Director@ means the director of rate setting.

(3) Division@ means the division of rate setting.

(4) State-assisted@ means a person eligible for or receiving benefits administered by or in coordination with the agency.

(5) Provider@ means any entity, excluding a hospital or a physician, providing services to state-assisted persons pursuant to a contract or other form of agreement with the state.

(6) Secretary@ means the secretary of human services.

Sec. 10. 33 V.S.A. § 901 is amended to read:

§ 901. REIMBURSEMENT OBJECTIVES

Reimbursement rates *[~~under the Medicaid program~~]* for nursing homes shall reflect the following objectives:

(1) Maintain an equitable and fair balance between cost containment and quality care in nursing homes.

(2) Encourage nursing homes to admit persons without regard to their source of payment.

(3) Provide an incentive to nursing homes to admit and provide care to persons in need of comparatively greater care.

(4) Be manageable administratively for both the state and nursing homes.

(5) Prevent unnecessary cost increases.

Sec. 11. 33 V.S.A. § 902(a) is amended to read:

(a) There is hereby created in the agency of human services a division of rate setting which shall *[~~be the successor to and continuation of the nursing home rate setting committee heretofore established under subchapter 3 of this chapter~~]* provide the agency of human services with special financial, accounting, auditing and related legal expertise for the purpose of rate setting and such other duties as the secretary shall direct.

Sec. 12. 33 V.S.A. § 904 is amended to read:

§ 904. RATE SETTING

(a) The director shall establish by rule procedures for determining payment rates for care of *[~~Medicaid recipients who are residents of Medicaid certified nursing homes~~]* state-assisted persons to nursing homes and to such other providers as the secretary shall direct. The rates determined for nursing homes under this chapter shall reflect the objectives of this chapter and shall be reasonable and adequate to meet the costs which the director finds must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards, subject to section 910 of this chapter.

(b) No *[~~Medicaid~~]* payment shall be made to any nursing home, on account of any state-assisted person unless the nursing home is certified to participate in the *[~~Medicaid~~]*state/federal medical assistance program *[~~under Title XIX of the Social Security Act~~]* and has in effect a provider agreement.

Sec. 13. The catchline of 33 V.S.A. § 905 is amended to read:

§ 905. BASIS FOR DETERMINATION OF NURSING HOME RATES

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Sec. 14. 33 V.S.A. § 907(a) is amended to read:

(a) The director shall establish payment limits for each cost category, or subdivision thereof, which, for nursing homes, are consistent with the provisions of section 901 of this title*[~~. Such limits shall~~]* to encourage the economic and efficient operation of nursing homes and other providers.

Sec. 15. 33 V.S.A. § 908 is amended to read:

§ 908. POWERS AND DUTIES

(a) Each nursing home or other provider shall file with the division, on request, such data, statistics, schedules or information as the division may require to enable it to carry out its function.

(b) The division shall have the power to examine books and accounts of any nursing home or other provider caring for *[~~state-aided~~]* state-assisted persons, to subpoena witnesses and documents, to administer oaths to witnesses and to examine them on all matters of which the division has jurisdiction.

(c) The secretary shall *[~~have the authority under the Administrative Procedure Act to promulgate~~]* adopt all rules and regulations necessary for the implementation of this *[~~subchapter~~]* chapter.

Sec. 16. 33 V.S.A. § 909(a) is amended to read:

(a) A *[~~party who~~]* nursing home that feels aggrieved by a final order of the division may:

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Sec. 17. 33 V.S.A. § 910 is amended to read:

§ 910. *[~~FUNDING OF DIVISION EXPENSES~~]* AVAILABILITY OF PAYMENT FOR

NURSING HOME SERVICES

[~~From time to time as the division may determine, each nursing home with persons aidedin whole or in part by the state through its social welfare programs shall be assessed its pro rata share of the cost of operating the division. The allocation of cost shall be made on the basis of the number of patient-days of persons so aided in each home. The assessed charges shall be included as a cost of doing business in the division's determination of payments for services and facilities.~~]

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In addition to any other reductions required by this act, the secretary may, with 90 days' notice to the nursing home, reduce the number of days of nursing home service or the number of nursing home beds for which payments are available under the state/federal medical assistance program in order to meet state budgetary goals, provided that the standards of care, required by section 7117 of this title and by rule, adopted by January 1, 1997, are maintained.

Sec. 18. 33 V.S.A. § 7117 is amended to read:

§ 7117. RULES

(a) In accordance with chapter 25 of Title 3, the *[~~licensing agency~~]* secretary of human services may adopt reasonable rules to carry out the provisions of this chapter, and may prescribe minimum standards of care, program, administration and sanitation for facilities licensed under this chapter.

(b) *[~~The secretary of human services may adopt interim rules under 3 V.S.A. chapter 25, limited to assuring minimum nursing care standards for community care homes. The interim rules shall expire on July 1, 1982.~~]* No later than January 1, 1997, the secretary of human services shall adopt comprehensive rules for licensing of nursing homes to include criteria deemed appropriate by the secretary, including criteria for accessibility, quality and safety standards. The rules for nursing home licensing shall:

(1) require that nursing facilities provide the care and services necessary to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with a comprehensive assessment and plan of care and prevailing standards of care as determined by the commissioner of aging and disabilities; and

(2) promote a standard of care that assures that the ability of each resident to perform activities of daily living does not diminish unless the resident's ability is diminished solely as a result of a change in the resident's clinical condition.

Sec. 19. COMMISSION ON PUBLIC HEALTH CARE VALUES AND PRIORITIES

The Commission on Public Health Care Values and Priorities shall promote dialogue among consumers, providers and state policy makers about the choices, alternatives and emerging trends in long-term care, in order to assure that consumers' preferences are reflected in the design of the long-term care delivery system and the composition of the long-term care budget.

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