



**STATE AUDITOR'S REVIEW**  
**OF THE**  
**DEPARTMENT OF AGING AND DISABILITIES**  
**IMPLEMENTATION OF ACT 160**

**STATE OF VERMONT**  
**OFFICE OF THE STATE AUDITOR**  
**MONTPELIER, VERMONT**

**ISSUED: MAY 15, 2000**

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**May 1996 to December 1999**

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**Appendix A: Department of Aging and Disabilities' Response to Draft Review**

**STATE AUDITOR'S REVIEW**  
**of**  
**THE DEPARTMENT OF AGING & DISABILITIES' IMPLEMENTATION**  
**of**  
**ACT 160**

**Executive Summary**

The Office of the State Auditor has conducted a compliance review of the Department of Aging & Disabilities' implementation of Act 160 of 1996 ("An Act Relating to the Coordination, Financing and Distribution of Long-term Care Services") for the period from May 1996 to December 1999.

Act 160 requires Vermont to shift, from FY 1997 to FY 2000, approximately \$20 million dollars in Medicaid funds from nursing homes to community-based services. "The law's intent is to finance and direct the development of a long-term care system, which provides the appropriate balance between institutional care and the home and community-based services most consumers desire. By shifting funds from the institutional sector to the community-based sector, it is intended that more people needing long-term care services will receive them."<sup>1</sup>

Prior to Act 160, public expenditures for all types of long-term care were \$83.5 million. Of that total, nursing homes received \$73.9 million and \$9.6 million was spent on home and community-based care. In FY 99, the total had grown to \$91.3 million, an increase of 9.2%. During the period, nursing home expenditures grew by less than 1%, while expenditures for home and community-based services grew 74%. At the end of FY 99, the share of public dollars expended for home and community-based care had grown from 11.5% to 18.5%. The negligible increase in nursing home expenditures is especially noteworthy since the average annual rate of growth prior to Act 160 was 9.35% and because nursing homes have received mandatory annual inflation increases. If that rate of growth had continued, nursing home expenditures in FY 99 would have been approximately \$95.8 million.

Notwithstanding the shift of some expenditures to home and community-based care, the availability of nursing home beds appears to be adequate. According to the Department, there were 319 vacant nursing home beds at the end of 1999 compared to 202 at the end of 1996.

**Findings**

Our review found that the Department is in substantial compliance with a number of the significant requirements outlined in the Act. Specifically, we found that:

- **The Department has reduced the rate of increase for nursing home expenditures and increased funding for home and community-based services since Act 160 was adopted. However, external factors such as federal budget cuts and regulatory changes have hampered the Department's ability to reduce nursing home expenditures.**
- **Based on the information reviewed, there has not been a reduction in the overall quality of nursing home services as a result of Act 160.**

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<sup>1</sup> Department of Aging & Disabilities, Legislative Oversight Report, Act 160, January 1997, p.1.

- **The Department has complied with the requirement to utilize Act 160 funds (money redirected from nursing homes) to develop and / or expand required home and community-based programs.**
- **The Department is in compliance with the requirement to distribute shifted funds among the required categories of consumers.**
- **The Department has substantially complied with the requirement to implement a comprehensive long-term care information system.**
- **The Department has substantially complied with the requirement to implement a state-wide long-term care service coordination and case management system.**
- **The Department has substantially complied with the requirement to consult with the required parties when proposing and implementing activities designed to reduce Medicaid nursing home expenditures.**
- **Current Federal Medicaid law and regulations impede the Department's ability to design and implement a voucher program for home and community-based long-term care services as required by the Act.**

We recommend that the Department continue to report to the Legislature those federal budgetary and regulatory changes that hamper its ability to reduce nursing home expenditures and expand home and community-based options.

## **Background**

Act 160 directed the Agency of Human Services to complete a number of budgetary, programmatic, policy and management initiatives related to long-term care by redirecting funds from institutional-based to home and community-based care services. Most of these initiatives fall within the jurisdiction of the Department of Aging and Disabilities (the Department).

A recent State publication reported that "long-term care services assist people whose independence has been compromised due to illness or disability. Since the advent of Medicaid, nursing homes have been the principal source of long-term care services."<sup>2</sup> Over the last fifteen years, Medicaid dollars spent on nursing homes have more than doubled, from \$30 million in 1985 to \$75 million in 1999.

An important element of long-term care involves personal assistance services. "Personal assistance services ... are non-medical services that enable an individual with functional, cognitive or psychiatric limitations to live in their home or another non-institutional setting. Non-medical services are considered to be services that an individual would do for him or herself if [the condition] did not limit one's ability to do them. Personal assistance services are a part of the continuum of services needed by individuals with chronic conditions and disabilities."<sup>3</sup> Because they are ongoing, personal assistance services are considered long-term care.

<sup>2</sup> *Health Resource Management Plan 1996-99*, Vermont Health Care Authority, March 15, 1996, p.93.

<sup>3</sup> *A Cost Analysis of Personal Assistance Services for Vermont*, BISHCA, May 1997, pp.ii and 8.

In 1995, there were an estimated 15,155 individuals in Vermont that needed personal assistance services and approximately fifteen percent (15%) of all public expenditures for long-term care were spent on personal care services. Many of the recent innovations in the delivery of long-term care reflect the growing need for non-medical services by those who require some assistance with daily living but for whom institutionalization is not necessary. Studies in other states have found that home and community-based care programs “can save substantial amounts of money by deterring institutionalization under the right circumstances” and that “serving an individual in the community is about 16% less expensive than serving an individual in a nursing home facility.”<sup>4</sup>

Surveys indicate that a majority of the chronically ill prefers to avoid institutionalization unless and until it’s absolutely necessary. Prior to the enactment of Act 160, the availability of home and community-based services was limited. Act 160 was adopted in response to the dual concerns about rising costs and Vermonters’ desire to stay in the most independent, least restrictive environments. Unfortunately, current state and federal laws favor nursing homes even as more community-based alternatives have been developed. For example, state law provides mandatory and annual inflationary increases in nursing home rates. Federal law also provides an entitlement to Medicaid-reimbursed nursing home care but no such entitlement exists for home and community based care.

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<sup>4</sup> *ibid*, p.42.

**State Auditor's Review  
of  
The Department of Aging & Disabilities'  
Implementation of Act 160**

**I. PURPOSE**

The Office of the State Auditor has conducted a compliance review of the Department of Aging & Disabilities' (the Department) implementation of Act 160 of 1996 ("An Act Relating to the Coordination, Financing and Distribution of Long-term Care Services"). The review was initiated as a result of inquiries by legislators and covers the period May 1996 to December 1999.

**II. AUTHORITY**

This review was conducted pursuant to the State Auditor's authority contained in 32 V.S.A. §§ 163 and 167, and was performed in accordance with the U.S. General Accounting Office's Government Auditing Standards [and as part of the State Auditor's annual audit of the State's General Purpose Financial Statements and its Federal Assistance Programs].

**III. SCOPE and METHODOLOGY**

The scope of this review included compliance with Act 160 and related statutes and regulations, as well as a limited review of internal control systems within the Department.

A review differs substantially from an audit conducted in accordance with applicable professional standards, in that the purpose of an audit is to express an opinion. The purpose of a review is to identify findings and make recommendations so that the reviewed agency, in this case the Department, can better accomplish its mission and more fully comply with laws and regulations. This review relies upon representations of, and information provided by, the Department and staff. If an audit had been performed, the findings and recommendations may or may not have differed from those presented.

Our methodology included a review of relevant state statutes and regulations, departmental reports to the legislature, data collected by the Department, as well as interviews with Department staff and selected long-term care providers.

**IV. BACKGROUND**

Act 160 directed the Agency of Human Services to complete a number of budgetary, programmatic, policy and management initiatives related to long-term care redirecting funds from institutional-based to home and community-based care services. The majority of these initiatives fall within the jurisdiction of the Department of Aging and Disabilities (the Department) and this review focused on the activities of the Department as they relate to Act 160.

A recent State publication reported that "Long-term care services assist people whose independence has been compromised due to illness or disability. Since the advent of Medicaid,

nursing homes have been the principal source of long-term care services.”<sup>1</sup> The public sector cost of long-term care has risen dramatically in the last few decades. Over the last fifteen years, Medicaid dollars spent on nursing homes has more than doubled: \$30 million in 1985, \$75 million in 1999.<sup>2</sup>

An important element of long-term care involves “personal assistance services.” “Personal assistance services ... are non-medical services that enable an individual with functional, cognitive or psychiatric limitations to live in their home or another non-institutional setting. Non-medical services are considered to be services that an individual would do for him or herself if [the condition] did not limit one’s ability to do them.”<sup>3</sup> “Personal assistance services are a part of the continuum of services needed by individuals with chronic conditions and disabilities. The ongoing nature of personal assistance services places them in the category of long-term care.”<sup>4</sup> Personal assistance services include:

- personal care (e.g., bathing and personal hygiene, dressing and grooming, eating, mobility tasks, toilet functions, help with self-administered medications);
- household services (e.g., cleaning, laundry, shopping, meal preparation);
- life management services (money management, scheduling, planning, crisis services);
- transportation;
- infant and child care;
- security and safety services (e.g., periodic in-person or telephone monitoring);
- care for support animals;
- home delivered meals; and
- respite.

In 1995, there were an estimated 15,155 individuals in Vermont that needed personal assistance services.<sup>5</sup> Approximately fifteen percent (15%) of all public expenditures for long-term care were spent on personal care services.<sup>6</sup>

Many of the recent innovations in the delivery of long-term care reflect the growing need (and demand) for non-medical services by those who require some assistance with daily living but for whom institutionalization is not necessary. Studies in other states have found that home and community-based care programs “can save substantial amounts of money by deterring institutionalization under the right circumstances”<sup>7</sup> and that “serving an individual in the community is about 16% less expensive than serving an individual in a nursing home facility.”<sup>8</sup>

Vermont’s nursing home industry is dominated by for-profit entities. Of the 44 licensed homes, 30 are for-profit and 14 are not-for-profit.<sup>9</sup> Over half of all licensed nursing home beds are owned and operated by for-profit nursing homes that are part of regional or national chains not based in Vermont (see Chart 1 on next page).

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<sup>1</sup> *Health Resource Management Plan 1996-99*, Vermont Health Care Authority, March 15, 1996, p.93.

<sup>2</sup> Source: Department of Aging & Disabilities.

<sup>3</sup> *A Cost Analysis of Personal Assistance Services for Vermont*, Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), May 1997, p.8.

<sup>4</sup> *A Cost Analysis of Personal Assistance Services for Vermont*, BISHCA, May 1997, p.ii.

<sup>5</sup> *A Cost Analysis of Personal Assistance Services for Vermont*, BISHCA, May 1997, p.33.

<sup>6</sup> This includes expenditures by the Departments of Aging & Disabilities, Health, Developmental & Mental Health Services, and the Office of Health Access (Medicaid). BISHCA report, May 1997, pp.20-21.

<sup>7</sup> *A Cost Analysis of Personal Assistance Services for Vermont*, BISHCA, May 1997, p.42 (Lewin Group).

<sup>8</sup> *A Cost Analysis of Personal Assistance Services for Vermont*, BISHCA, May 1997, p.42 (1994 GAO report).

<sup>9</sup> There are three other nursing homes in Vermont but they don’t accept Medicaid so they are not included in this report (Wake Robin, Arbors, & Merten’s).

Surveys indicate that a majority of the chronically ill prefers to avoid institutionalization unless and until it's absolutely necessary.<sup>10</sup>

Unfortunately, current state and federal laws favor nursing homes even as more community-based alternatives have been developed.<sup>11</sup> Some efforts to implement changes designed to produce savings in the system have met with resistance from the nursing home industry.<sup>12</sup>

Prior to the enactment of Act 160, the availability of home and community-based services was quite limited (see page 10 for descriptions).

Chart 1<sup>13</sup>

Percentage of nursing home beds by category

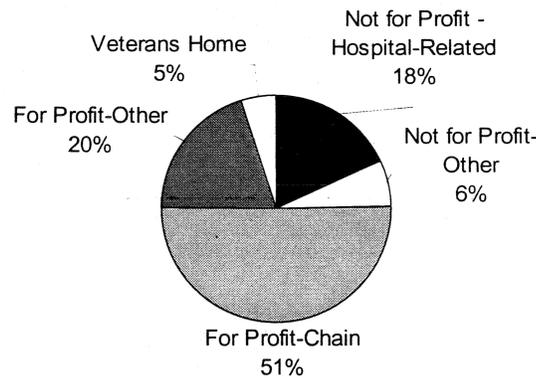


Table 1

Availability of Home and Community-Based Services Before and After Act 160 <sup>14</sup>		
Program / Service	Pre - Act 160	Post - Act 160
H&CB Medicaid Waiver	350 on waiting list; 621 unduplicated recipients 9/94-2/96	10 on waiting list; 890 unduplicated recipients 3/98-2/99
Enhanced Res. Care	Did not exist	140 unduplicated recipients 3/98-2/99
Attendant Services Program	148 on waiting list; 270 served	180 on waiting list*; 308 served
Alzheimer's/Dementia Respite	Did not exist	133 families served
Hope in Housing	Did not exist	Pilots in Rutland & Windham Co.
Residential Care Homes (RCH)	136 RCH's; 2,351 lic. beds 8/96	113 RCH's;** 2,129 lic. beds 10/99
Adult Day Services	12 providers; 13 sites; 702 people served; 176,605 units of service	12 providers; 17 sites; 761 people served; 201,186 units of service

\* The waiting list has grown due to increased referrals and because the average hrs of service / recipient has increased 20%.

\*\* Decline in RCH's and licensed beds is largely a result of factors unrelated to Act 160 (i.e., flat reimbursement rates).

Thus, Act 160 was adopted in response to the dual concerns about rising costs and Vermont's desire to stay in the most independent, least restrictive environments. "The Act requires Vermont to shift, over the next four years, approximately \$20 million dollars in Medicaid funds from nursing homes to community-based services. The law's intent is to finance and direct the development of a long-term care (LTC) system which provides the appropriate balance between institutional care and the home and community-based services most consumers desire. By shifting funds from the institutional sector to the community-based sector, it is intended that more people needing long-term care services will receive them."<sup>15</sup>

<sup>10</sup> Department of Aging & Disabilities, Legislative Oversight Report, Act 160, January 1998, p.1.

<sup>11</sup> For example, state law provides mandatory and annual inflationary increases in nursing home rates. Federal law provides an entitlement to Medicaid-reimbursed NH care but no such entitlement exists for H&CB care.

<sup>12</sup> According to Department staff, representatives of the nursing home industry opposed the implementation of the Department's nursing home pre-admission assessment and the Dept. decided to delay implementation.

<sup>13</sup> Source: Department of Aging & Disabilities.

<sup>14</sup> Source: Department of Aging & Disabilities.

<sup>15</sup> Department of Aging & Disabilities, Legislative Oversight Report, Act 160, January, 1997, p.1.

# V. COMPLIANCE FINDINGS

## A. Reduction in Medicaid nursing home expenditures:

### FINDING 1

The Department of Aging and Disabilities has reduced the rate of increase for nursing home expenditures and increased funding for home and community-based services since Act 160 was adopted. However, external factors such as federal budget cuts and regulatory changes have hampered the Department's ability to reduce nursing home expenditures.

**DISCUSSION:** Section 2(a) of the Act requires the Agency of Human Services to reduce nursing home expenditures by about \$20 million from FY 1997 through FY 2000.<sup>16</sup>

As indicated in the charts below, prior to the enactment of Act 160, public expenditures for all types of long-term care were \$83.5 million. Of that total, nursing homes received \$73.9 million and \$9.6 million was spent on home and community-based care. In FY 99, the total had grown to \$91.3 million, an increase of 9.2%. During the period, nursing home expenditures grew by less than 1%, while expenditures for home and community-based services grew 74%. At the end of FY 99, the share of public dollars expended for home and community-based care had grown from 11.5% to 18.5%.

Chart 2<sup>17</sup>

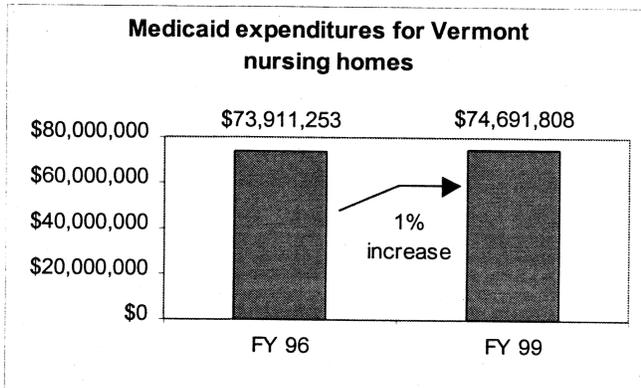


Chart 2b

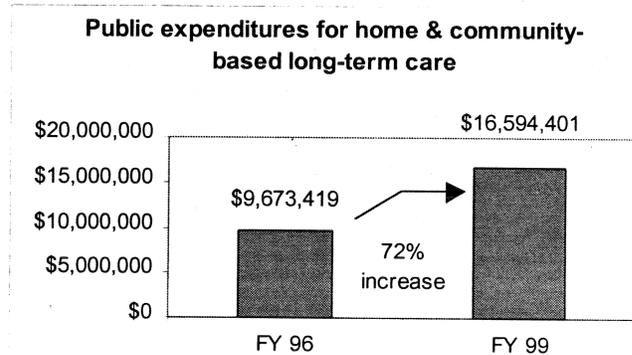


Chart 3a

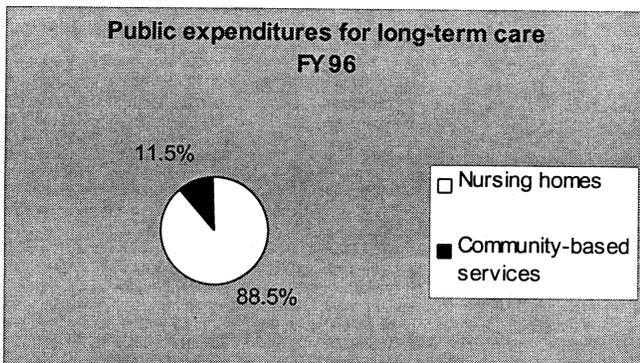
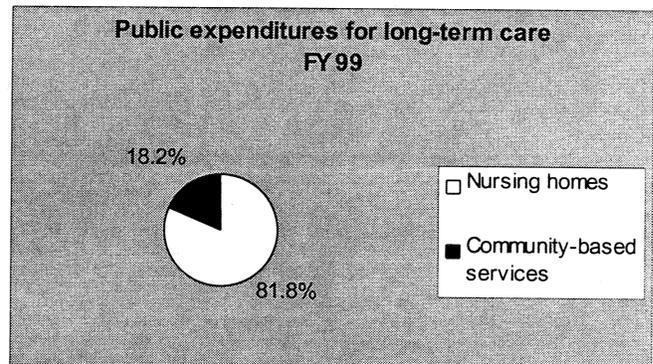


Chart 3b

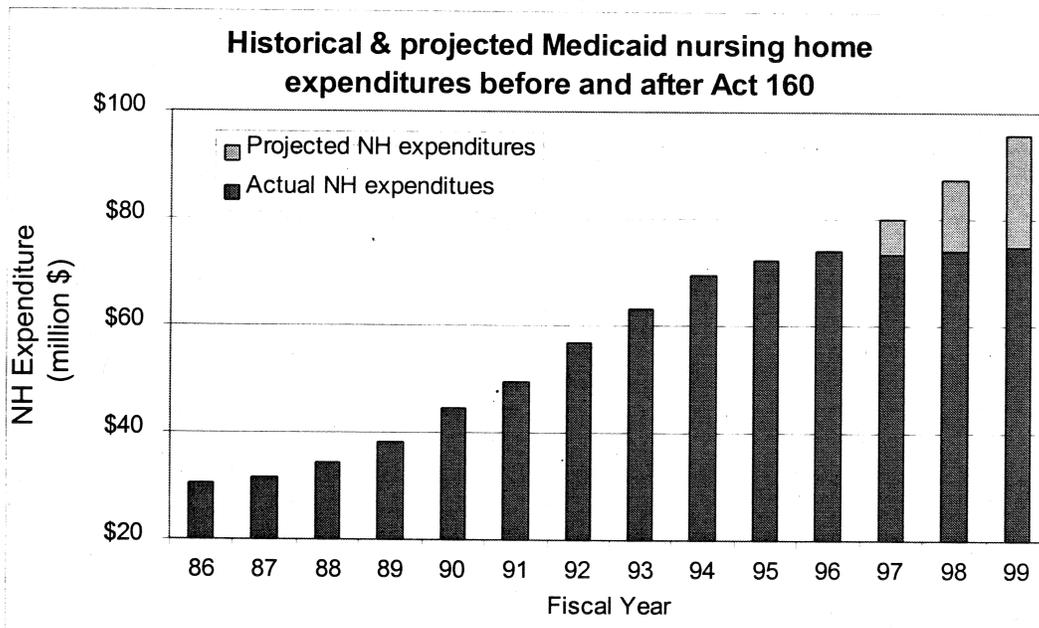


<sup>16</sup> The amount is determined by a formula that multiplies specified numbers of nursing home beds times the average annual expenditure for a nursing home bed in each fiscal year.

<sup>17</sup> Source for Charts 2a, 2b, 3a and 3b: Department of Aging & Disabilities

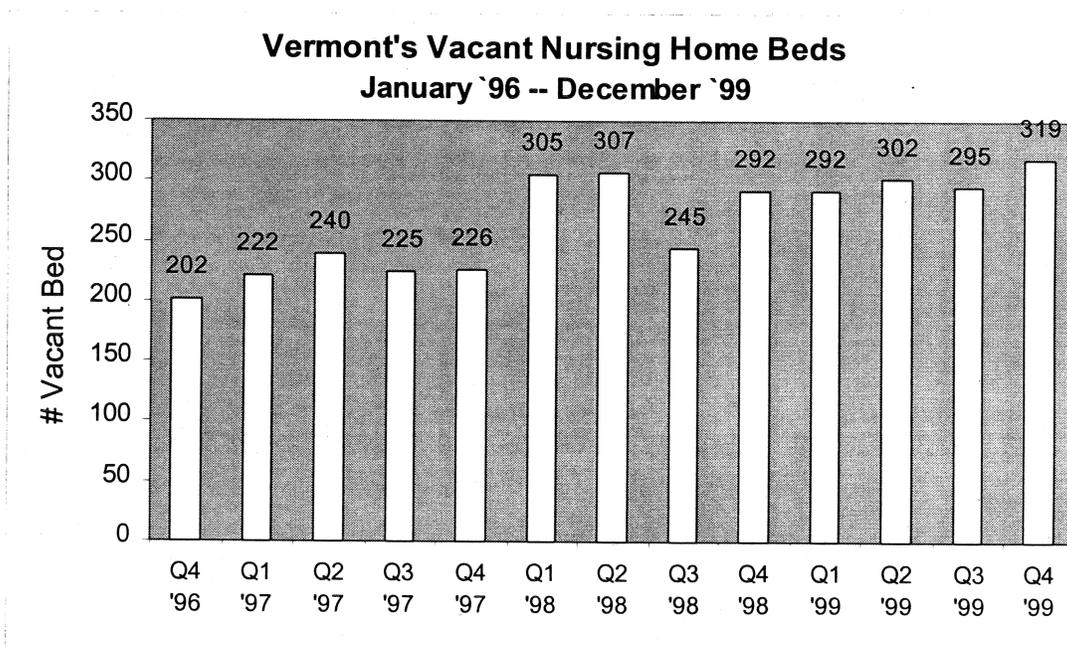
The negligible increase in nursing home expenditures is especially noteworthy since the average annual rate of growth prior to Act 160 was 9.35%. If that rate of growth had continued, nursing home expenditures in FY 99 would have been approximately \$95.8 million<sup>18</sup> (see Chart 4). The slow rate of growth is especially noteworthy because nursing homes have received mandatory annual inflation increases.

Chart 4



Notwithstanding the shift in expenditures, the availability of nursing home beds appears to be adequate. The current number of vacancies is 319 up from 202 at the end of 1996.

Chart 5



<sup>18</sup> According to Department staff, the leveling in the rate of growth in FY 96 resulted from pre-Act 160 administrative responses to rising Medicaid NH expenditures (e.g., the Certificate of Need moratorium on new nursing home beds).

The distribution of these vacancies is not consistent throughout the state, however (see Table 2).

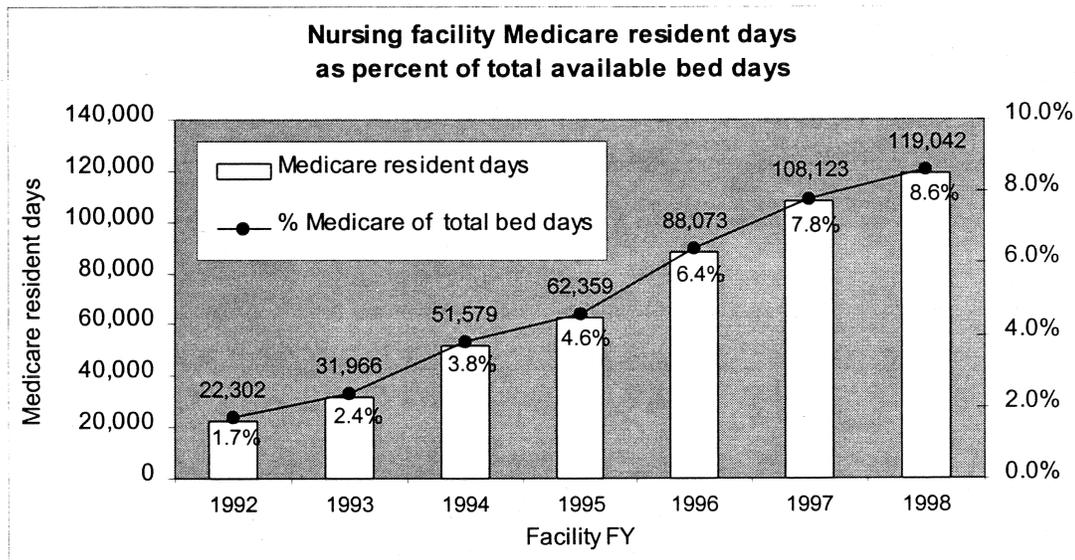
Table 2

Licensed NH beds & vacancies by County-12/99 <sup>19</sup>				
County <sup>20</sup>	Beds	Lic. beds / 1,000 75+	Vacancies	% Vacant
Addison	135	84	15	11.1%
Bennington	545	133	93	17.1%
Caledonia	170	92	3	2.0%
Chittenden	551	97	21	3.8%
Franklin	214	107	13	6.1%
Lamoille	130	119	4	3.1%
Orange	80	54	14	17.5%
Orleans	272	168	17	6.3%
Rutland	451	105	5	1.1%
Washington	459	123	30	6.5%
Windham	392	141	76	19.4%
Windsor	330	92	28	8.5%
<b>Totals</b>	<b>3,729</b>	<b>avg. 107</b>	<b>319</b>	<b>8.6%</b>

Act 160 is not the only reason for the higher vacancy rates. According to one nursing home administrator, the average length of stay has dropped, which results in higher turnover.<sup>21</sup> The expanded utilization of Medicare funds (as opposed to Medicaid) has led to increased admissions of post-operative hospital patients who go to nursing homes for intensive short-term care or therapy. Greater use of Medi-

care has been going on for some time, however, as the percentage of all Medicare nursing home days has grown from 1.7% in 1992 to over 8.6% in 1998<sup>22</sup> (see Chart 6). The policy was first encouraged by the state in the early '90's as a means of limiting the growth of Medicaid expenditures (which include a state match). Changes to the Medicare reimbursement rate have made the shift advantageous for nursing homes because the Medicare rate is now \$134 / day higher than the Medicaid rate.<sup>23</sup>

Chart 6



In any case, the distribution of vacancies varies considerably by category (see Chart 7 on the next page).

<sup>19</sup> Source: Department of Aging & Disabilities.

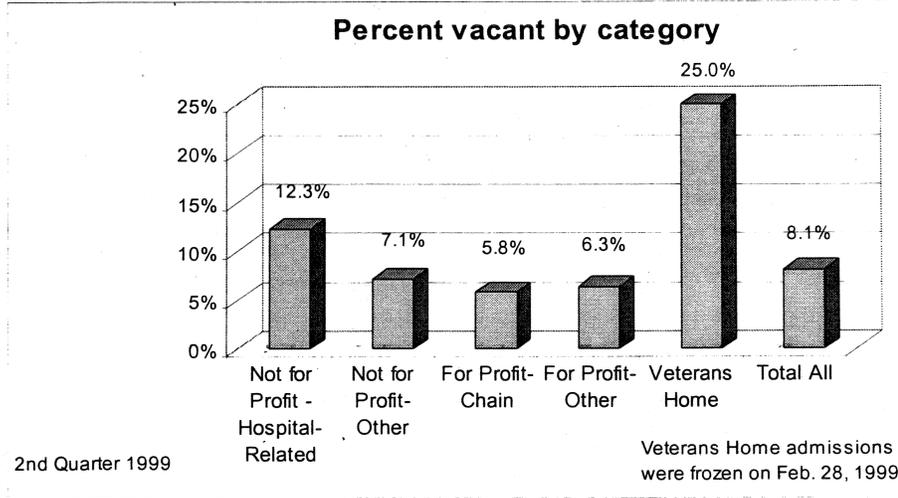
<sup>20</sup> There are no licensed nursing homes in Essex or Grand Isle Counties.

<sup>21</sup> October 7, 1999 telephone conversation between Richard Morley (Subacute) and Doug Hoffer (SAO). Subacute owns 7 facilities with 766 licensed beds, roughly 20% of the total statewide.

<sup>22</sup> October 15, 1999 telephone conversation between Julie Wasserman (DAD) and Doug Hoffer (SAO).

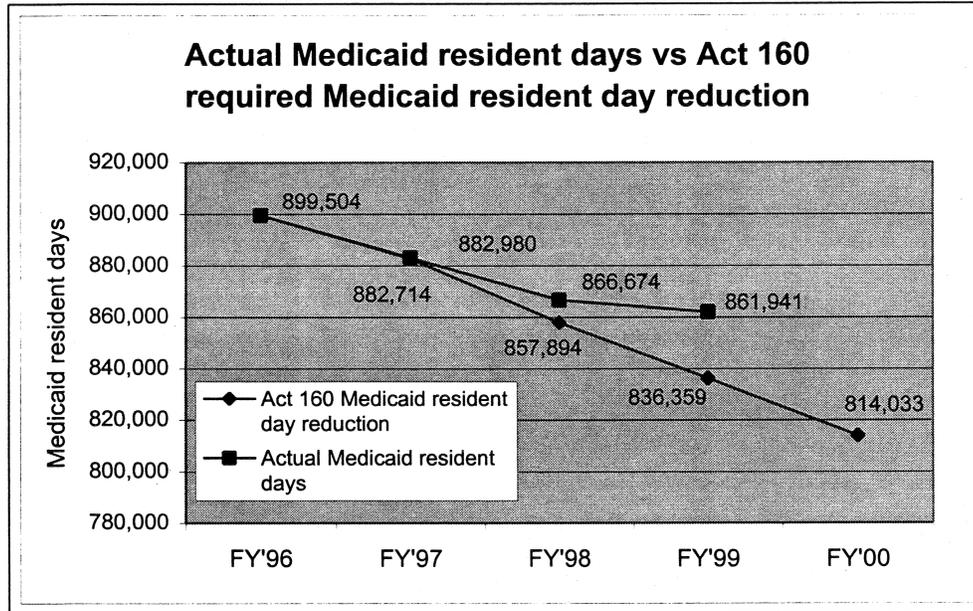
<sup>23</sup> March 13, 2000 memorandum from Julie Wasserman (DAD). In 1993, the difference was \$43 / day.

Chart 7



Act 160 called for a cumulative reduction in Medicaid resident days of 9.5% through FY 2000. The Department met the first annual goal, as shown in Chart 8, but the rate of reduction has slowed and has not kept pace with the Act's prescription for the last two years.

Chart 8



Federal budget-cuts and changes in the residential care sector have limited the Department's ability to achieve the mandated shift of resources. "The federal Balanced Budget Act of 1997 made significant changes in the way Medicare reimburses home health agencies for the services they provide to beneficiaries. In an effort to contain growth and provide incentives to operate efficiently, Congress imposed new caps on Medicare payments to home health agencies [that] penalized agencies that had already achieved low per person costs."<sup>24</sup> This resulted in a loss of about \$7 million in annual funding for the thirteen certified home health agencies and more cuts are scheduled. Anecdotal evidence suggests that cutbacks in services have forced some home health clients to seek admission to nursing homes instead.<sup>25</sup>

<sup>24</sup> Certificate of Need Guidelines, BISHCA, March 15, 1999.

<sup>25</sup> It's impossible to track patient's movements into and out of homes & institutions without a patient ID number.

The federal Health Care Financing Administration's (HCFA) new interpretation of the "homebound" requirement is much more restrictive than before and deprives many Vermonters of the opportunity to remain independent while still receiving services.<sup>26</sup> There is considerable disagreement about the interpretation of the "homebound" rule.<sup>27</sup>

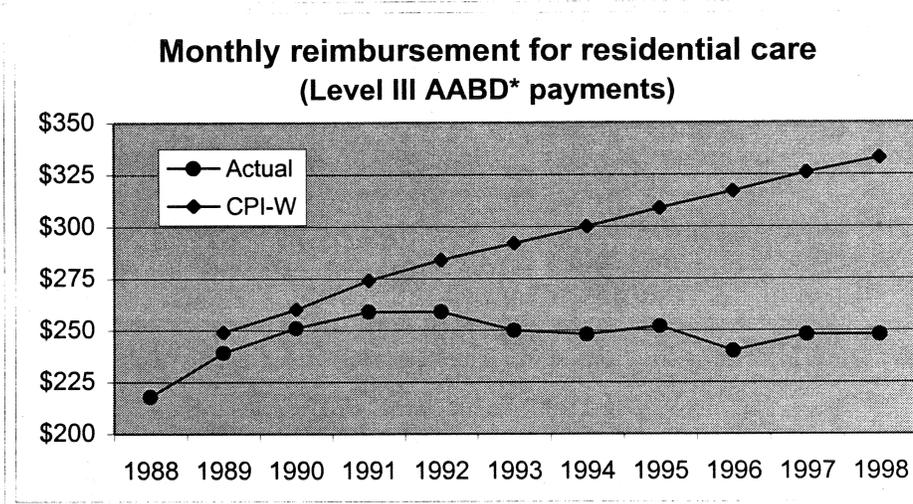
According to Department staff, more than 200 residential care beds have been lost to closures in the last two years. "Residential care homes play a unique role in the long-term care system, providing 24-hour oversight and care for individuals no longer able to live independently"<sup>28</sup> but who do not require nursing home care.

The federal Medicare Balanced Budget Act of 1997 also reduced the funds available for nursing homes through changes in reimbursement schedules. For example, services that had been reimbursed at cost are now paid based on "expected" costs using figures from prior years. The Act also eliminated reimbursement for some services altogether, such as ambulance rides for nursing home patients that need regular dialysis treatment at the hospital.

The problems experienced by residential care homes are largely the result of inadequate reimbursement for services. Unlike nursing homes, which receive mandatory and automatic annual inflation increases, residential care home reimbursements have not kept pace with costs (see Chart 9 below). Furthermore,

many residential care homes are small "mom and pop" operations that occupy older housing stock. The state's understandable concern about the safety of these facilities often requires costly repairs to meet codes.

Chart 9<sup>29</sup>



\* Aid to the Aged, Blind & Disabled

<sup>26</sup> According to the attorney for the VT Assembly of Home Health Agencies (VAHHA), data from HCFA, the Federal Intermediary, and VAHHA indicate a decline in the number of people served of 800 - 1,000 since the new payment procedures were adopted (November 2, 1999 letter from Phil White to Julie Wasserman).

<sup>27</sup> The Homebound rule is one of several eligibility criteria beneficiaries must meet to qualify for Medicare home health coverage. The dispute centers on HCFA's interpretation of a guideline (HIM 11) that establishes acceptable reasons for leaving home, and the frequency and duration of such trips. According to the home health agencies, HCFA has frequently denied coverage for home health patients who are chronically (but not acutely) ill, suffer from dementia or other mental impairment, or attend adult day centers for non-medical reasons (VAHHA newsletter, Summer, 1999, pp.4-6). It is noteworthy that those who appeal a denial of coverage due to HCFA's new interpretation of the homebound rule are almost always successful on appeal to the Administrative Law Judges (ALJ) who hear the cases. According to the Fiscal Intermediary for HCFA (Associated Hospital Service of Maine – AHSM), "approximately 90% of appeals are reversed" by the ALJ's (September 24, 1999 letter from Paul Duplinsky (AHSM) to William Dombi (National Association for Home Care).

<sup>28</sup> Department of Aging & Disabilities, The Act 160 Legislative Oversight Report, January 1999, p.2.

<sup>29</sup> Source: Department of Aging & Disabilities.

## **RECOMMENDATION 1**

The Department should continue to report on those federal budgetary and regulatory changes that hamper its ability to reduce nursing home expenditures.

### **B. Assuring continued quality:**

#### **FINDING 2**

We found no evidence that there has been a reduction in the overall quality of nursing home services as a result of Act 160.

**DISCUSSION:** Section 2(c) of the Act states that “the reductions required in subsection (a) shall not have the effect of diminishing or reducing the quality of services available to nursing home residents.”

The Department’s Division of Licensing and Protection annually surveys nursing homes to determine the number and nature of deficiencies.<sup>30</sup> The results show an overall improvement since 1996. Total deficiencies have declined. The number of nursing homes with deficiencies indicating potential or actual harm has declined. On the other hand, the number of nursing homes with a “pattern” of deficiencies indicating potential or actual harm has increased. This suggests that while there has been improvement systemwide, the severity of deficiencies has increased at a small number of nursing homes.

## **RECOMMENDATION 2**

No recommendation.

### **C. Distribution of Act 160 funds for home and community-based services:**

#### **FINDING 3**

The Department has complied with the requirement to utilize Act 160 funds (money redirected from nursing homes) to develop and / or expand the specified programs.

**DISCUSSION:** Section 2(d) of the Act requires that the reductions mandated in subsection (a) be redirected to home and community-based services including, but not limited to, ten (10) programs delineated in the Act. The ten (10) programs listed in the Act include:

1. *Home and community-based waiver.* Allows Medicaid funds to be used for home and community-based services for those who choose not to be institutionalized and can be adequately served in the community. Services include personal care, adult day services, respite, case management and assistive devices.
2. *Traumatic brain injury waiver.* Allows Medicaid funds to be used for community-based rehabilitation services to allow individuals to return from expensive out-of-state facilities and be near their families.
3. *Residential care homes:* The Enhanced Residential Care Waiver allows Medicaid funds to be used for services (including light nursing care) provided in residential care homes.

<sup>30</sup> Department of Aging & Disabilities, Division of Licensing and Protection, Survey Tracking Report, 1996 – 1999.

4. *Attendant services program*: Personal care to help individuals with a disability live independently.
5. *Homemaker services program*: Housekeeping, respite, and limited personal care services.
6. *Older American Act funds*: These federal funds are the primary funding source for the Area Agencies on Aging and provide some funding for Legal Aid and Department administration.
7. *Adult day services and home health expenditures for long-term care*: Services include recreation, health, respite and advocacy for those with significant impairments.
8. *Vermont independence fund*: Funding for organizations testing innovative long-term care ideas.
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*: The Dementia Respite Care Program offers respite care to enable families to care for relatives at home and avoid nursing home admission.
10. *Any other long-term care support services available*: Medicaid Waiver Designated Administrative Agencies (community-based organizations that manage the Home-Based Waiver and Residential Care Waiver) and Hope in Housing (senior congregate housing) among others.

Table 3 shows the Department's use of public funds before and after Act 160 was enacted. Act 160 funds are monies shifted from nursing homes to home and community-based care. The figures show the increment of state funds expended annually above the base year before Act 160 was adopted. "Other sources" include the DSW Medicaid appropriation and matching state funds from the General Fund, and taxes on nursing homes and home health agencies. The greatest increase in funding was for the Home-based Medicaid Waiver program.

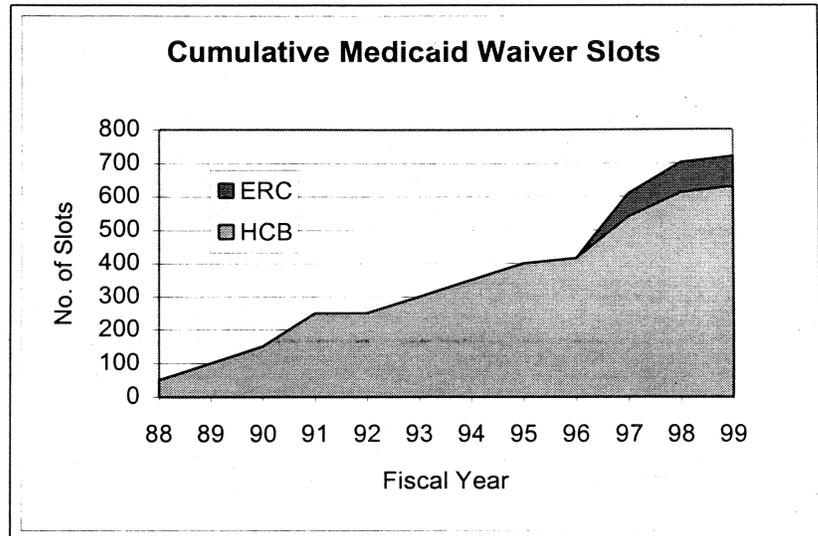
Table 3<sup>31</sup>

Pre- and Post-Act 160 Expenditures by Program					
Program / Type of Care	FY 96	FY 97 -- 99			FY 99
	Pre-Act 160 Annual Expenditure	Aggregate Act 160 Funds	Aggregate Other Sources	"Shifted" Funds All sources	Annual Expenditure
Home-based Medicaid Waiver	\$4,648,871	\$3,105,220	\$3,054,736	\$6,159,956	\$8,232,900
Traumatic Brain Injury Waiver	985,163	0	1,018,857	1,018,857	1,467,847
Enhanced Res. Care Medicaid Waiver	0	0	1,580,267	1,580,267	771,738
Attendant Services	1,803,585	298,558	952,171	1,250,729	2,688,193
Homemaker Program	561,071	0	(247,627)	(247,627)	538,079
Adult Day Services	665,687	500,000	0	500,000	915,687
VT Independence Fund	19,698	115,755	0	115,755	88,948
Dementia Respite Care	0	125,000	150,000	275,000	200,000
Medicaid Waiver Desig. Admin. Agencies	0	242,944	0	242,944	161,272
Hope in Housing	0	71,369	0	71,369	53,526
Community Coalitions	0	341,304	0	341,304	255,277
Flexible Funds / Misc.	0	147,575	0	147,575	51,590
Area Agencies on Aging	989,344	0	360,000	360,000	1,169,344
Nursing home quality indicators	0	59,070	0	59,070	59,070
Administration	0	133,293	18,322	151,615	109,439
Miscellaneous	0	71,200	4,024	75,224	20,912
<b>Totals</b>	<b>\$9,673,419</b>	<b>\$5,211,288</b>	<b>\$6,890,750</b>	<b>\$12,102,038</b>	<b>\$16,783,822</b>

<sup>31</sup> Source: Department of Aging & Disabilities.

The Department has had some success at securing Medicaid Waiver slots<sup>32</sup> from the Legislature for Home and Community-Based Care and Enhanced Residential Care, although there is unmet demand<sup>33</sup> (see Chart 9).

Chart 9<sup>34</sup>



Note: The Department does not determine how many Waiver slots are made available. The Department of Banking, Securities, Insurance and Health Care Administration (in cooperation with the Department) estimates unmet demand in the Nursing

Home Level of Care Need Determination every three years. The Legislature and the Governor make the final decision about the number of allowable nursing home beds and/or Waiver slots as part of the annual budget process. However, the Legislature and the Governor are not mandated to meet unmet demand either through new Waiver slots or nursing home beds.

### **RECOMMENDATION 3**

The Department, as well as the AAA's and the hospitals, should provide consumers with as much information as possible about the available options for services.

### **FINDING 4**

The Department has complied with the requirement to transfer unspent redirected funds to the long-term care special administrative fund.

**DISCUSSION:** Section 2(d) of the Act requires that "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."

The Department reported the following: 1) at the end of FY 97, \$312,313 remained in the special administrative account; 2) at the end of FY 98, there was \$337,276 in the account; and 3) the account balance was zero at the end of FY 99.<sup>35</sup> Although these funds were not spent during a given fiscal year, Department staff reported that the money represented commitments made in one fiscal year but carried over to the next.

### **RECOMMENDATION 4**

No recommendation.

<sup>32</sup> A Waiver slot is equivalent to a nursing home bed; one slot can serve one person with home or community-based services. Like a nursing home bed, if one person leaves, another can take his / her place.

<sup>33</sup> There were 278 people on Waiver waiting lists in 1998. BISHCA, CON, May, 1999, Appendix B, p.B-1.

<sup>34</sup> Source: Department of Aging & Disabilities.

<sup>35</sup> October 20, 1999 e-mail from Julie Wasserman (DAD) to Doug Hoffer (SAO).

## **FINDING 5**

The Department is in compliance with the requirement to distribute shifted funds among the required categories of consumers.

**DISCUSSION:** Section 2(e) of the Act requires that shifted funds “shall be distributed among the following categories of consumers:

- Nursing home residents who desire to transfer to a home and community-based setting and for whom such transfer is medically appropriate and cost-effective;
- People on waiting lists for publicly-funded programs as of July 1, 1996, and at the highest risk of nursing home placement;
- People at the highest risk of nursing home admission; and
- People with the greatest social and economic need.”

Following the adoption of Act 160, the Department adopted prioritization criteria that targeted home and community-based waiver services to individuals with the greatest needs, as required by the Act. Assignment of Medicaid Waiver slots is now preceded by a review of priority evaluation forms completed by case managers from the Designated Administrative Agencies (Area Agencies on Aging and Home Health Agencies) and / or members of the Medicaid Waiver teams from the local / regional Coalitions [see Finding 7 below, page 13, Discussion item (A)]. The evaluative forms involve scoring each applicant on measures of impairment, supports, and “indicators of imminent nursing facility admission.” In addition to its intended purpose of allocating Waiver slots for individuals, the systematic use of the priority assessments allows the Department to track Waiver utilization by region. If it is determined that one area is under-utilizing its allotment, the Department can reassign the unused slots to another area where the need may be greater.

## **RECOMMENDATION 5**

No recommendation.

## **D. Implementation**

### **FINDING 6**

The Department has substantially complied with the requirement to implement a comprehensive long-term care information system.

**DISCUSSION:** Section 3(b)(1) of the Act requires the Department to “implement the initial phase of a comprehensive data system that tracks long-term care expenditures, services, consumer profiles and consumer preferences.”

The Department’s Senior Assessment and Management System (SAMS) database is designed to track client and service delivery information and was brought on line in 1995 (prior to the enactment of Act 160). SAMS is comparable to the nursing home resident assessment already required by the federal government (i.e., the Minimum Data Set -- MDS). In addition, the federally mandated client assessment now required of the Home Health Agencies (Outcome and Assessment Information Set – OASIS) will provide information on individuals receiving services.

The Department requires residential care homes to complete functional assessment forms at the time of admission, as well as annually thereafter and if there's a significant change in the individual's condition. This assessment tool crosswalks with the MDS for nursing homes but not with OASIS. According to Department staff, OASIS (required by HCFA) is intended primarily to measure quality improvement rather than resident's capacity and, therefore, doesn't crosswalk well with the other assessment tools.<sup>36</sup> Finally, the functional assessment conducted by residential care homes is not yet handled electronically because the residential care homes are not yet equipped for data entry.<sup>37</sup> At present, most residential care homes use traditional paper forms to report to the Department.

### **RECOMMENDATION 6**

The Department should consider assisting residential care homes "that are not yet equipped for data entry." This could include loans or grants for equipment and staff training.

### **FINDING 7**

The Department has substantially complied with the requirement to implement a statewide long-term care service coordination and case management system.

**DISCUSSION:** Section 3(b)(2) of the Act requires the Department to "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." The Act specifies numerous components of the required system (see below). The Act requires that, at a minimum, the system must include the following components:

(A) *"A request for proposal process by which the [department] may authorize local entities to administer local long-term care services."*

The Department conducted a thorough RFP process. After developing a draft RFP, the Department submitted it for comment to numerous individuals and groups on March 19, 1997. Following a meeting with interested parties to answer questions about the initiative on April 8, the Department accepted comments on the draft until April 25, 1997. In response to the comments, the Department issued a memorandum on March 19 that explained the revised process. On July 1, 1997, the Department issued a Request for Letters of Intent and a Request for Proposals (business plans) from community-based coalitions interested in partnering with the Department.

Eventually, "the Department issued grants to eight regional coalitions to fund new or expanded services that the local coalitions have determined might delay or prevent institutionalization. The coalitions are composed of providers and consumers."<sup>38</sup> Two other coalitions are in earlier stages of development. The eight active coalitions received a total of \$255,277 of Act 160 funds in FY 99.

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<sup>36</sup> October 15, 1999 telephone conversation between Julie Wasserman (DAD) and Doug Hoffer (SAO).

<sup>37</sup> Item #10 in an attachment to an August 30, 1999 letter from Julie Wasserman (DAD) to John Howland, Deputy State Auditor in response to an information request.

<sup>38</sup> "The Act 160 Legislative Oversight Report," Department of Aging & Disabilities, January, 1999.

- (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.”*

According to staff, “the Department has a comprehensive assessment tool (the Independent Living Assessment – ILA) which is used for a variety of programs and cross-walks with the nursing home assessment. The ILA is used for the Medicaid Waiver, Attendant Services, Adult Day Services, Homemaker program, and all services provided by the Area Agencies on Aging.”<sup>39</sup> As noted above in section C.1., however, home-health agency providers use the federally-mandated OASIS assessment tool rather than the ILA. As a result, information collected by the various providers is not always comparable.

- (C) *“Coordination of all long-term care services administered by the [departments of aging and disabilities, health, and mental health and mental retardation (MHMR)].”*

According to Department staff, this initiative was slow in starting but has received more attention recently. For example, the Department is now collaborating with MHMR on transportation, housing, adult day care, dementia, osteoporosis, and case management. The Department is also participating in Health Department programs on injury and diabetes prevention and is attempting to work with the Health Department to provide support for local volunteers and link them with the coalitions.<sup>40</sup>

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

The Department provides consumer information about long-term care services on its web site and distributes written materials through the five (5) Area Agencies on Aging, home health agencies, hospitals, and “Waiver teams” from the local coalitions.

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

The Department has had an Advisory Board for many years, as required by the Department’s original enabling statute. The Board “shall advise the commissioner on matters related to the interests of older persons and persons with disabilities.”<sup>41</sup> The Board is comprised of 24 members including at least fourteen who are older persons or persons with disabilities. Membership must also include regional representation.

In addition, the Department staffs at least ten other boards including (but not limited to) the State Independent Living Council, Vocational Rehabilitation Council, Alzheimer Commission, Advisory Council on Traumatic Brain / Spinal Cord and Head Injuries, Assistive Technology Coordinating Council, Adaptive Equipment Revolving Fund, Division of Blind & Visually Impaired Advisory Council, Eligibility Committee for Attendant Care Services, Governor’s Committee on the Employment of People with Disabilities, and Randolph Sheppard Vendors Association of Vermont.

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<sup>39</sup> Item #12 in an attachment to an August 30, 1999 letter from Julie Wasserman (DAD) to John Howland, Deputy State Auditor in response to an information request.

<sup>40</sup> October 15, 1999 telephone conversation between Julie Wasserman (DAD) and Doug Hoffer (SAO).

<sup>41</sup> 33 V.S.A. § 505.

- (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 non-institutionalization 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.”*

The Department has used Act 160 funds to support a variety of alternative service delivery models (see Table 1 on page 3). For a variety of reasons, the assisted living model has not evolved as hoped. The Department drafted rules to regulate the operation of such facilities but, according to Department staff, advocates for the residential care home industry opposed them.<sup>42</sup> Apparently, the definition of “assisted living” in the proposed regulations would have prevented residential care homes from marketing themselves as assisted living facilities. In addition, the private sector has not built the necessary facilities.<sup>43</sup>

### **RECOMMENDATION 7**

No recommendation.

### **FINDING 8**

The Department has substantially complied with the requirement to consult with the required parties when proposing and implementing activities designed to reduce Medicaid nursing home expenditures.

**DISCUSSION:** Section 3(b)(3) requires the Department to consult “with the nursing home industry, consumer advocates, consumers and other long-term [care] service providers, [to] propose and implement methods to contain costs and encourage the reduction of Medicaid nursing home expenditures.”

The methods suggested in the Act for containing costs and reducing Medicaid nursing home expenditures include:

- a. *maximize Medicare billing to pay for nursing home care;*

As is shown in Chart 6 (p. 6), the nursing home industry has increased Medicare billing consistently over the past decade.

- b. *reduce the number of nursing home beds;*

The moratorium on nursing home bed construction and licensing has effectively controlled the number of nursing home beds. Since Act 160 was enacted, total capacity has decreased by fifty nine (59) beds [sixty-seven (67) beds lost to closures / downsizing and eight (8) beds have been added<sup>44</sup>].

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<sup>42</sup> October 15, 1999 telephone conversation between Julie Wasserman (DAD) and Doug Hoffer (SAO).

<sup>43</sup> October 6, 1999 telephone conversation between Julie Wasserman (DAD) and Doug Hoffer (SAO).

<sup>44</sup> Source: Department of Aging & Disabilities.

- c. *eliminate or modify state nursing home rules that are not cost-effective and don't advance the quality of care;*

The last progress report of the "Deregulation Group" (which was comprised of government and industry representatives) concluded that existing nursing home regulations are appropriate and have improved care. The Group made no substantive recommendations for eliminating or modifying state nursing home rules.<sup>45</sup>

- d. *apply for exemptions from federal nursing home regulations to improve efficiency and reduce administrative costs for the industry.*

See item c. above.

- e. *propose new or modified rules (subject to certificate of need review) that permit:*

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

According to Department staff, the Department works closely with the Coalitions (which include providers) to address these issues.<sup>46</sup>

- 2) *greater cooperation between nursing homes and providers of home care, respite care, adult day care and other long-term [care] services;*

See item e.(1) above.

- 3) *The use of nursing home beds as respite beds.*

Based on information supplied by the Department, nursing homes are encouraged to offer respite services to Medicaid recipients and individuals participating in the Medicaid Waiver program. If the nursing home admits an individual for short-term respite care, the assessment requirements are less demanding than the normal procedures.<sup>47</sup>

However, the use of vacant nursing home beds for respite has been limited due to: "1) Medicaid is the only source of payment for this service [so] if a person does not qualify for Medicaid, s/he has to pay for the service out-of-pocket; 2) it is difficult to match empty beds with the specific schedules of families needing respite; [and] 3) nursing homes have not pursued this market."<sup>48</sup>

- f. *Changes in the state Medicaid plan to permit Medicaid billing for community residential care homes;*

The Department of Social Welfare recently adopted a new policy that permits Medicaid billing for "assistive community care services" provided in residential care homes.<sup>49</sup>

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<sup>45</sup> January 17, 1996 memorandum from Margie Perry, Chair of the Deregulation Group, to Richard Morley (Subacute).

<sup>46</sup> November 3, 1999 telephone conversation between Julie Wasserman (DAD) and Doug Hoffer (SAO).

<sup>47</sup> December 23, 1998 memorandum from Bard Hill (Chief, H&CB Services for the Department) and November 3, 1999 draft memorandum from Bard Hill, Laine Lucenti (Director, Div. Of Licensing & Protection), and Kathy Haskins (DSW).

<sup>48</sup> November 4, 1999 memorandum from Julie Wasserman (DAD) to John Howland, Deputy State Auditor.

<sup>49</sup> Department of Social Welfare Bulletin No. 99-12FP, July 1, 1999. According to Department staff, the new policy was conceived and co-developed by the Department of Aging & Disabilities.

- 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.*

The Department commissioned a study of alternative financing strategies for long-term Care that analyzed the seven strategies listed in the Act. The author's conclusion was that "no one strategy will be able to provide long-term care financing for all the long-term care needs of Vermonters. The social insurance model comes the closest to providing universal coverage but, depending on the benefit design, it may provide coverage for only a portion of the long-term care needs of Vermonters. Without consensus on moving forward with a social insurance model, a multi-strategy approach will be necessary. However, a multi-strategy approach may require a considerable amount of time before it has the effect of decreasing the reliance on Medicaid for long-term care financing."<sup>50</sup>

### **RECOMMENDATION 8**

No recommendation.

### **FINDING 9**

The Department is not in compliance with the requirement to design and implement a voucher program for home and community-based long-term care services, but has offered a reasonable explanation for not doing so. Moreover, the Department's Attendant Services Program and the consumer-directed options under the Medicaid Waiver program actually achieve the same objectives as a voucher program.

**DISCUSSION:** Section 3(b)(4) requires the Department to "design and implement a voucher program that permits consumers to design, manage and pay for their home and community-based services.

According to the Department, they have "not yet implemented a voucher program, for good reason. The drafters of Act 160 were unaware of the very real obstacles in federal Medicaid law and regulation regarding use of Medicaid dollars for a 'voucher' program. For example, Medicaid does not permit funds to be given directly to consumers for unspecified services. Nor does Medicaid permit funds to be 'saved' and then used for whatever purpose by the consumer at a later time. Because of these obstacles, and others, the Robert Wood Johnson Foundation (RWJ) issued a request for proposals to explore these issues through pilot projects in partnership with HCFA. This RWJ initiative began when Act 160 commenced. Once the Department realized it could not implement a voucher program without a special waiver from HCFA, and knowing that HCFA was just beginning a pilot to explore the issues, we felt we had to wait for the outcomes of the pilot before we proceeded."<sup>51</sup> The Department hired a consultant to track the HCFA/RWJ pilot but thus far only two states are moving forward.

The Department further noted that the "Attendant Services Program (ASP) approximates a voucher program, as anticipated by many of the interested parties. ASP participants can hire, fire, train and supervise their own attendants, and [the Department] takes care of payroll and tax paperwork for them. In conjunction with 'flexible funds' available through Act 160, an

<sup>50</sup> Boget, Beverly, "An Analysis of Alternative Financing Strategies For Long-Term Care," 1997, p.iii.

<sup>51</sup> Item #13 in an attachment to an August 30, 1999 letter from Julie Wasserman (DAD) to John Howland, Deputy State Auditor in response to an information request.

ASP consumer experiences many of the attributes of a voucher program. Unfortunately, ASP relies entirely on state General Fund dollars so there are fiscal constraints associated with expansion. However, we have extended some of the same 'consumer directed' options to participants in our Medicaid Waiver programs, and these options are the fastest growing cost center in the Medicaid Waiver.<sup>52</sup>

### **RECOMMENDATION 9**

The Department should continue to track the Robert Wood Johnson initiative and report to the Legislature when the results of the pilots are available.

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<sup>52</sup> Item #13 in an attachment to an August 30, 1999 letter from Julie Wasserman (DAD) to John Howland, Deputy State Auditor in response to an information request.

## **APPENDIX A**

**Department of Aging and Disabilities' Response to Draft Review**



State of Vermont

AGENCY OF HUMAN SERVICES

DEPARTMENT OF AGING AND DISABILITIES

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APR 17 2000

April 14, 2000

Edward S. Flanagan, Vermont State Auditor  
Office of the State Auditor  
133 State Street  
Montpelier, VT 05633-5101

Dear Mr. Flanagan,

Thank you for your thorough and comprehensive report regarding the Department of Aging and Disabilities' compliance with Act 160. Given the complicated nature of the long term care system, your report excels at distilling the essential elements. We appreciate your acknowledgement of the Department's efforts in implementing Act 160.

Although your report touches on many of the critical issues, we would like to underscore two of the biggest obstacles to "shifting the balance" between institutional and non-institutional care: the federal entitlement to Medicaid coverage of nursing home care and the lack of what we call "options counseling".

First, anyone who qualifies clinically and financially for Medicaid coverage in a nursing home is entitled under federal and state law to receive that care. Meanwhile, persons eligible for home care services under our Home and Community Based Waiver must wait in line. Furthermore, because of consumer interest we have to prioritize access to our waiver. This has hindered our efforts because we know that some people who couldn't wait any longer for home-based Waiver services entered a nursing home because that service was available and an entitlement. Over the past 35 years, this Medicaid nursing home entitlement has been largely responsible for the imbalance and consequent inadequacy of public funding for non-institutional long term care. We continue to search for a vehicle to correct this imbalance and let consumers have more equal choice of the type of care that they desire, which is the real heart of Act 160.

Second, many individuals enter a nursing home without ever being fully informed of the other options available for long term care. We routinely hear anecdotes that individuals are not even given a choice. To remedy this, it is our intention to develop a new program

Edward S. Flanagan, State Auditor  
April 14, 2000  
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this year to provide information about options prior to nursing home admission and to ensure that consumers are provided with the opportunity to choose from among those options.

We appreciate your attention to this dynamic environment in long term care.

Sincerely,

A handwritten signature in cursive script that reads "Patrick Flood". The signature is written in black ink and is positioned above the printed name.

Patrick Flood, Commissioner