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MEDICAID FACTS

THE HENRY J. KAISER FAMILY FOUNDATION

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THE VERMONT CHOICES FOR CARE LONG-TERM CARE PLAN: KEY PROGRAM CHANGES AND QUESTIONS

In June 2005, Vermont was given federal approval for a Section 1115 waiver to make fundamental changes to its Medicaid program that provides long-term services and supports to eligible, low-income state residents. The waiver was designed to increase access to home and community-based services (HCBS), reduce use of institutional services, and control overall costs for long-term services spending. The state hopes to achieve these goals by limiting access to nursing facility care and increasing the availability of HCBS. The program is subject to available funding under a global cap. The program was implemented on October 1, 2005 and is estimated to serve about 4,000 individuals annually. Today, Vermont spends 60 percent of its long-term care expenditures on care in the community, ahead of the national average of 46 percent.

What Long-Term Service Changes Occurred in Vermont?

The waiver established three levels of need for long-term services. Individuals are assigned to one of three groups using an independent living assessment that has been in use to determine eligibility for existing state waiver programs. Only individuals in the "highest need" group are guaranteed access to long-term services.

"Highest Need" Group: Individuals are entitled to either nursing home or community services. Individuals will be placed in the "highest need" group if they meet specific functional criteria including the need for extensive or total assistance with at least one of the following: toileting, bed mobility, eating or transferring; if they have a severe impairment with decision-making, or have a moderate impairment and exhibit certain other behaviors; or if they meet certain other criteria.

"High Need" Group: Individuals have access to long-term services within the waiver as funds become available. This group consists of individuals who do not meet the criteria for the "highest need" group, but have extensive needs for personal care and rehabilitation services.

Many of the persons in the "high need" group were previously receiving services through the home and community-based services waiver program. These individuals will be grandfathered into the program and are not at risk of losing services if resources are not available to the state. For beneficiaries in the "high need" group who become eligible for long-term services after the demonstration starts, however, the services they receive are subject to adequate resources being available to serve them.

"Moderate Need" Group: This group is an expansion population not previously receiving Medicaid long-term services. It consists of persons who do not qualify for an institutional level of care. Individuals in this group are served with a specific set aside of funds.

The waiver includes most long-term services users in the state. The waiver includes all beneficiaries in nursing homes, in the previous home and community-based waivers, in the Enhanced Residential Care (ERC) waiver and new PACE program participants. The waiver excludes children, persons in Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), and limited other exclusions.

The waiver does not alter financial eligibility criteria. Individuals are income eligible with income up to 300% of SSI ($1,809 per month for a single individual in 2006), but individuals can spend-down to 300% of SSI to qualify. Persons are resource eligible for nursing home care with $2,000 in resources, but individuals who own and reside in their own homes are eligible for community services with $5,000 in resources, excluding the home. If funding is available, this limit will be phased up to $10,000.

The waiver covers only long-term services and tiers services according to need, subject to available funding. Acute care services, such as physician and hospital services, are not affected by the waiver. Also, home health services, including physical, occupational and speech therapy are not affected and remain covered outside of the waiver. The following services will be made available at all times to the "highest need" group and to the "high need" group as funds are available:

- Nursing Facility Settings: 24-hour skilled nursing, specialized rehabilitation, personal care, medication management, meals, social and recreational activities, 24-hour supervision, laundry, housekeeping, nutritional services, and social services.
- Home-Based Settings: Case management, personal care, adult day care, respite care, companion services, personal emergency response systems and assistive devices, and home modifications.
- Enhanced Residential Care (ERC) Settings: Case management, nursing overview, personal care, medication management, social and recreational activities, 24-hour supervision, laundry, and housekeeping services.

Persons in the "moderate need" group are eligible only for case management, adult day care, and homemaker services.

Waiver participants will be charged co-payments for community services. For persons in the "highest need" and "high need" groups, cost sharing is limited by regular Medicaid rules. There is no cost sharing provision for "moderate need" services.

The waiver operates under a five-year global budget cap. Vermont's funding for all long-term services, including nursing facility and HCBS services are subject to an aggregate cap set at $1.236 billion. This amount is based on projections regarding the demand for, and cost of, long-term services by low-income elderly and individuals with disabilities in Vermont. If actual costs exceed this level, the state is responsible for any additional costs or it will have to limit services provided to stay under this cap. Under the waiver, the state hopes to save $61 million on existing populations through greater use of HCBS, and would use $56 million of that for spending on the "high" and "moderate need" groups.

Other Features. The demonstration is operating as a managed care program, but Medicaid providers are not capitated and providers are not at-risk financially. The demonstration includes a "Cash and Counseling" consumer direction component. The demonstration also permits the state to engage in selective contracting with nursing homes, however, this feature is not yet implemented.

Current Enrollment Status. By narrowing eligibility for nursing home care and expanding community services, the state plans to provide long-term services to more individuals in less costly settings. Enrollment as of June 2006 reached 3,906 individuals, with more people being served under the new waiver than prior to the start of the waiver (Figure 1). The program is also providing limited community supports to an additional 449 individuals who are classified as "moderate need" individuals.

Figure 1

Demonstration Participation

Historical Experience (SFY 2003)		Actual Enrollment (June 2006)	
Nursing Home	2,101	Nursing Home	Highest Need 2,130 High Need 13
HCBS Waiver	958	HCBS Waiver	Highest Need 944 High Need 157
ERC Waiver	142	ERC Waiver	Highest Need 177 High Need 36
		Moderate Need	449
Total	3,201	Total	3,906

Sources: Vermont Revised Budget Neutrality Projections, May 7, 2004 and Vermont Department of Disabilities, Aging and Independent Living Enrollment Report, June 2006.

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Key Questions

Will the level of community supports be sufficient to prevent the need for nursing home care? The adequacy of services for individuals who need long-term services is especially urgent for "highest" and "high need" group individuals, in particular for individuals with "high needs" who meet an institutional level of care standard, but have no guarantee of any services. As of June 2006, 68 "high need" individuals were on the waiting list compared with 241 individuals on a wait list for HCBS services prior to the start of the waiver.

Will the assessment process fairly and appropriately determine the level of need? It is not known how effectively the screening and assessment process will evaluate individuals and assign them to a level of eligibility. This is complicated by the fact that the need for services can vary significantly over time and across populations. Monitoring will be necessary to follow how well changing needs will be accommodated.

Is there adequate capacity to provide community services? The state has established several goals for rebalancing its service delivery system. It will be important to monitor whether there is adequate capacity in Vermont to provide community services on the scale envisioned by the demonstration.

Will operating under a global cap limit services to those in need of long-term services? While the aggregate cap amount appears to be generous today, it will be important to monitor whether funding is sufficient to meet future service needs.

Conclusion

Virtually all stakeholders agree that Medicaid programs need to achieve a greater community orientation in their long-term services programs. Vermont's Long-Term Care Plan waiver gives the state significant new tools to limit Medicaid spending on nursing home care and to increase access to community-base services. However, questions remain over whether the encouragements to use community services are sufficiently balanced by safeguards to protect access to care in the most appropriate setting that is needed, whether in the community or in a nursing home.

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