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CHOICES FOR CARE: CONSUMER CHOICE AND STATE POLICYMAKING COURAGE AMID MEDICAID'S SHIFTING ENTITLEMENT TO LONG-TERM CARE

Tracy Bach*

"We are never going to build another nursing home," said Patrick Flood, Commissioner of Vermont's Department of Disabilities, Aging and Independent Living (DAIL) in 2006, "It is an outdated model."¹ Commissioner Flood made this declaration one year after the creation of Choices for Care (CFC), a Section 1115² waiver program that allows Vermont to encourage Medicaid-eligible state residents to receive long-term care in their homes rather than in nursing homes.³ By creating this new program, Vermont hopes to increase access to home

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1. Lucette Lagnado, *Seniors in Vermont Are Finding They Can Go Home Again*, WALL ST. J., Oct. 23, 2006, at A1, available at http://online.wsj.com/article_email/SB116137590566399273-1MyQjAxMDE2NjIxMzMzMzMyNm1Wj.html (last visited Feb. 2, 2008).

2. Section 1115 waivers is the common label given to waivers granted from 42 U.S.C. § 1315, which is Section 1115 of the Social Security Act. See Julia Belian, *State Implementation of the Optional Provisions of the Deficit Reduction Act*, 9 ELDER'S ADVISOR 63, 66 (2007) (discussing section 1115 waivers). This statute authorizes the Centers for Medicare and Medicaid Services (CMS) to waive a state's compliance with specific provisions of the Medicaid statute for state demonstration projects that are "likely to assist in promoting the objectives of [the Act]" 42 U.S.C. § 1315(a) (Westlaw current through Feb. 2, 2008).

3. Lagnado, *supra* note 1.

and community-based health and personal care services, decrease the use of institutional services, and bring down overall spending on long-term care services.⁴ The federal government approved the CFC waiver in June 2005,⁵ explicitly endorsing this new definition of long-term care entitlement in its approval letter:

CFC "[p]romotes the objectives of the Medicaid program and the Americans with Disabilities Acts by creating an entitlement of home and community-based services, for a group with the highest needs, within the long-term care infrastructure. Experience gained through this demonstration may pave the way for other states seeking to reduce the institutional bias of Medicaid."⁶

Albert Blow, a former security guard who was stricken by a heart attack and stroke,⁷ knows about this institutional bias. His medical condition landed him in a nursing home for what he hoped was short-term rehabilitation.⁸ But because he could not afford to spend his limited Social Security and pension checks on maintaining his apartment and car, a few months turned into many, and his options for leaving the Starr Farm Nursing Home dwindled.⁹ One day in 2004, he called his former wife and told her, "if I had a gun, I would shoot myself."¹⁰ However, when Vermont's CFC came into being, Mr. Blow went back to his own place.¹¹ With Section 1115 authorization, Vermont paid his former wife, who was a former licensed nurse, \$9.27 an hour to

4. See THE U.S. DEPT. OF HEALTH AND HUMAN SERV., LONG-TERM CARE SYSTEMS CHANGE FOR THE AGED AND AMERICANS WITH DISABILITIES: STATE PROFILES (2005) at 17, available at http://www.aoa.gov/press/fact/pdf/ib_ltc.pdf (last visited Feb. 2, 2008) (discussing Vermont's long-term care reform goals).

5. See Letter from Mark B. McClellan, Ctrs. for Medicare & Medicaid Serv., to Michael K. Smith, Secretary, Vt. Agency of Human Serv. (June 13, 2005), available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/VTLTC1115-Approval.pdf> (last visited Feb. 2, 2008) [hereinafter Approval Letter].

6. *Id.*

7. See Lagnado, *supra* note 1.

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

care for him.¹² Having this choice gave the 71-year-old man a new lease on life.¹³

CFC has had the opposite effect on the nursing home industry in Vermont. "We knew that this was probably the death knell for some of our nursing homes," said Mary Shriver, executive director of the Vermont Health Care Association.¹⁴ Long-term care analysts, while recognizing the inevitable changes that would result from the new Medicaid entitlement, have questioned whether the non-institutional setting urged by CFC truly benefits Vermont's seniors and whether it really is more cost-effective than traditional Medicaid-funded institutional care.¹⁵ For example, nursing homes provide the availability of round-the-clock care, while CFC recipients typically receive only twenty-five to thirty hours of care a week, which often is not provided on nights and weekends.¹⁶ In addition, government regulations require nursing homes to have basic safety infrastructure like fire alarms and sprinkler systems, and quality assurance mechanisms like licensed care providers.¹⁷

More fundamentally, given the mobility of younger generations throughout the United States and the resulting dearth of nearby family members to care for the elderly, even with compensation, some analysts question the CFC's reach.¹⁸ Given the hospital industry's "quicker and sicker" discharge mantra, direct discharge to nursing homes may often appear preferable than this fragile, home-based infrastructure.¹⁹

As Justice Brandeis famously wrote over a hundred years ago, "[i]t is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments

12. *Id.*

13. *See id.*

14. *Id.*

15. *See id.*

16. *Id.*

17. *Id.*

18. *Id.*

19. *Id.*

without risk to the rest of the country."²⁰ In the health care realm, states have experimented with a variety of initiatives to improve services, in light of their traditional authority to regulate and protect citizen health and welfare and the federal government's lack of sustained leadership.²¹ As Laura Tobler of the National Conference of State Legislatures recently observed, there has never been "so much health care reform activity bubbling on the horizon as now."²²

Americans age sixty-five and over comprise the fastest-growing segment of the population.²³ Providing them with medical and personal care is labor-intensive and costly.²⁴ Medicare has chosen not to insure long-term care.²⁵ Accordingly, the task of figuring out how to provide long-term care has largely fallen to the Medicaid program and the states that administer it.²⁶ Section 1115 programs like CFC enable the federal government to conduct small-scale experiments in long-

20. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

21. See, e.g., Eric Benson, *States Lead the Way on Health Insurance Reform*, 35 J.L. MED & ETHICS 329 (2007) (discussing state-based access initiatives to reduce the number of uninsured).

22. Clarke Canfield, *States Explore Health Reform*, BANGOR DAILY NEWS, Dec. 26, 2006, available at <http://bangordailynews.com/news/t/news.aspx?articleid=144555&zoneid=500> (last visited Feb. 2, 2008).

23. U.S. Census Bureau, *Facts for Features: Older Americans Month Celebrated in May*, http://www.census.gov/Press-Release/www/releases/archives/facts_for_features_special_editions/004210.html (last visited Feb. 2, 2008). In 2004, 36.3 million Americans, or 12% of the total population, were age sixty-five and older, and 4.9 million were eighty-five and older. *Id.* By 2050, a projected 86.7 million Americans, 21% of the total population, will be sixty-five and older. *Id.* This represents a 147% increase, compared to a 49% increase in the overall population during the same period. *Id.*

24. The average annual cost for a private room in a nursing home is \$74,806 and for living in an assisted-living facility, \$32,572. See Amer. Ass'n of Homes and Serv. for the Aging, *Aging Services: The Facts* (2007), http://www.aahsa.org/aging_services/default.asp (last visited Feb. 2, 2008). The average national hourly rate for a certified home health aide is \$32.37 while the same for a homemaker/companion is \$18. *Id.* The average national rate for an adult day care center is \$61 per day. *Id.*

25. See *id.*

26. See *Medicare Program Integrity: Hearing Before the Subcomm. on Health & Oversight & Investigations of the H. Comm. on Ways & Means*, 110th Cong. (2007) (statement of Timothy B. Hill, Chief Financial Officer) (discussing the federal government's role and objectives in administering Medicaid).

term care service design, which may “pave the way”²⁷ for a more coherent and cohesive system.²⁸

As one of the first states to receive a Section 1115 waiver to reorganize the long-term elder care delivery,²⁹ Vermont presents an interesting choice of experiment locale. First, a higher percentage of Vermonters are sixty-five years old and older, as compared to the overall U.S. population: 13.2% versus 12.4%.³⁰ Moreover, Vermont is an aging state, with elderly people projected to comprise nearly a quarter of the state’s population by 2030.³¹ It is a small state with a total population of only 624,000 people, and its median income hovers just above the national rate at \$44,548.³² Yet, 25% of Vermont’s population is covered by Medicaid, a relatively large percentage when compared to the national average of 18%.³³

Importantly, Vermont’s legislative and executive branches have demonstrated serious and sustained interest in making progressive health reform.³⁴ A few months after the federal government approved the CFC waiver, Vermont received approval of another Section 1115 waiver program called Global

27. See *supra* note 5 and accompanying text.

28. Lagnado, *supra* note 1.

29. *Id.*

30. U.S. Census Bureau, Vermont QuickFacts from the US Census Bureau , <http://quickfacts.census.gov/qfd/states/50000.html> (last visited Feb. 2, 2007) [hereinafter Vermont QuickFacts].

31. JULIE WASSERMAN, VT. AGENCY OF HUMAN SERV., DEP’T OF DISABILITIES, AGING & INDEP. LIVING, SHAPING THE FUTURE OF LONG TERM CARE AND INDEPENDENT LIVING 2006 i, (2007), available at <http://dail.vermont.gov/dail-publications/publications-annual-reports/shaping-the-future-2006-2016> (last visited Feb. 2, 2008).

32. Vermont QuickFacts, *supra* note 30.

33. CTRS. FOR MEDICARE & MEDICAID SERV., THE MEDICAID ANALYTIC EXTRACT CHARTBOOK 26 (2007), available at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/MAX_Chartbook_2007.pdf (last visited Feb. 2, 2008).

34. See WASSERMAN, *supra* note 31, at ii (referring to Vermont’s 1996 Act 160 as “landmark” legislation); see also JOCELYN GUYER, KAISER COMM’N ON MEDICAID AND THE UNINSURED, VERMONT’S GLOBAL COMMITMENT WAIVER: IMPLICATIONS FOR THE MEDICAID PROGRAM 5 (2006), available at <http://www.kff.org/medicaid/upload/7493.pdf> (last visited Feb. 2, 2008) (noting that Vermont’s Medicaid program “has long been watched by policymakers around the country as a program that sets trends, particularly among states with a strong commitment to providing and expanding health insurance.”).

Commitment, which allows the state to significantly alter its entire Medicaid program.³⁵ In exchange for accepting a \$4.7 billion cap on federal matching funds over a five-year term, Vermont may deviate from federal standards, including reducing benefits, increasing cost sharing, and limiting enrollment.³⁶ This experiment in federal-to-state financial risk shifting is, like CFC, in its early stages.

After two years of operation, one could readily conclude that the CFC experiment has yielded successful results. There has been steady enrollment growth since CFC was implemented on October 1, 2005: the new long-term care entitlement program currently serves almost 4,700 state residents, with nearly half of them choosing to receive care in the home or community.³⁷ In November 2006, the Council of State Governments awarded CFC its Silver Society Award for exemplary state programs addressing healthy aging.³⁸ As Governor Douglas proudly proclaimed when accepting this award, "[t]his is an option that is desired by Vermonters and saves the state money because community services cost less than institutional services. Saving money on nursing home services has enabled the state to reinvest those savings into serving more people."³⁹

Nonetheless, questions about CFC's efficacy abound. First, there are questions concerning its overall impact on Medicaid recipients who need skilled nursing care. In the first two years of operation, has CFC shifted long-term care from institutions

35. See GUYER, *supra* note 34, at 5-14 (discussing the Global Commitment waiver's features and goals).

36. *Id.* at 2.

37. See BARD HILL, VT. AGENCY OF HUMAN SERV., DEP'T OF DISABILITIES, AGING & INDEP. LIVING, CHOICES FOR CARE QUARTERLY DATA REPORT 3-4 (Oct. 2007).

38. Press Release, Vt. Agency of Human Serv., Governor Douglas and "Choices for Care" Staff Win National Award for Groundbreaking Program (Nov. 14, 2007), available at <http://humanservices.vermont.gov/news-info/ahs-press-releases/november-14-release-governor-douglas-and-201choices-for-care201d-staff-win-national-award-for-groundbreaking-program> (last visited Feb. 2, 2007). "Founded in 1933, the Council of State Governments (CSG) serves the executive, judicial, and legislative branches of state government through leadership education, research and information services. CSG promotes excellence in decision making and leadership skills and champions state sovereignty." *Id.*

39. *Id.*

into home and community settings? Has it spurred the establishment of new institutions, like adult day care and assisted- or independent-living facilities, and has it reshaped the home health care industry?

Second, there are questions concerning the program's cost-effectiveness. Is CFC managing long-term care costs and saving Vermont money? If so, is it using those savings to serve more people?

Third, there are questions concerning whether CFC has actually created additional costs. Given low Medicaid reimbursement rates, have shifts in utilization and attendant savings resulted in new or increased costs for providers via increased acuity of nursing home patients and bad debt for home health care agencies?

Finally, there is the fundamental question of whether CFC will radically change long-term care and influence other states. Is the program really "turning the ship around," as Wendy Fox-Grange, senior policy advisor with the AARP's Public Policy Institute, observed?⁴⁰ Will the Vermont program serve as a program model for reforming Medicaid's long-term care entitlement?

This article seeks to answer these questions and in doing so, to move the conversation beyond the beneficial individual choice that CFC entitled Albert Blow to make to the large-scale impact of such entitlement shifting. As the Baby Boomers begin to join the aging population,⁴¹ finding financially sustainable solutions to long-term care is necessary for our country's health and well-being, and for Medicaid's promise of health care entitlement to long-term care.

"A CRAZY SITUATION": TRADITIONAL MEDICAID FINANCING OF LONG-TERM CARE

Vermont's DAIL Commissioner Flood observed, when looking

40. Lagnado, *supra* note 1, at 6.

41. *See id.*

over the landscape of the federal government's health care financing decisions for long-term care, "It's a crazy situation. [The government guarantees the] service people don't want and is more expensive, while the service people prefer and is cheaper [is not guaranteed]." ⁴² According to one study, Medicaid paid \$122 a day for Vermont nursing home care in 2002, compared to \$80 a day for community-based care. ⁴³ Yet, since Medicaid's inception in the 1960s, federal law has created an entitlement to nursing home services while largely choosing to exclude coverage of community-based care. ⁴⁴ "Medicaid accounts for 40% of all long-term care services delivered and almost half of all nursing home expenditures in the United States, making Medicaid the nation's largest single payer of long-term care services." ⁴⁵ In 2005, Medicaid spent \$38 billion, or 82% of its long-term care budget, on institutional care, and only \$8 billion, or 18% of this budget, on community-based care. ⁴⁶ The current federal administration has labeled this policy choice as Medicaid's "institutional bias." ⁴⁷

The impact of this bias is magnified by Medicaid's interplay with the Medicare program. ⁴⁸ While most Americans think of

42. *Id.*

43. HILL, *supra* note 37.

44. See Christie Provost & Paul Hughes, *Medicaid: 35 Years of Service*, 22 HEALTH CARE FIN. REV. 141, 147-48 (2000) (discussing the trend in increasing long-term care expenditures for Medicaid, and that most long-term care is for institutional services).

45. ANNA SOMMERS ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID'S LONG-TERM CARE BENEFICIARIES: AN ANALYSIS OF SPENDING PATTERNS 1 (2006), <http://www.kff.org/medicaid/upload/7576.pdf> (last visited Feb. 3, 2008).

46. Lagnado, *supra* note 1. Notably, the proportion of Medicaid spending directed toward institutional long-term care has declined; in 2002, 87% was spent on nursing homes and only 13% on home and community-based care. See *id.*

47. See, Approval Letter, *supra* note 5. *Testimony on Medicaid Community-Based Care Before the Subcomm. on Health and Environment of the H. Commerce Comm.* (1998) (statement of Margaret P. Hamburg, Assistant Secretary for Planning and Evaluation, and Sally K. Richardson, Director, Center for Medicaid and State Operations, U.S. Department of Health and Human Services), available at <http://www.hhs.gov/asl/testify/t980312a.html> (last visited Feb. 2, 2008).

48. While Medicare is the federal health insurance program intended to cover health care services for Americans over sixty-five, Congress originally designed the benefit package to cover only acute hospitalization via Part A and outpatient medical care via Part B. BARRY R. FURROW ET AL., HEALTH LAW 735-43 (5th ed.

Medicare as the public insurance scheme for the elderly and Medicaid as the public insurance program for the poor, usually imagined as women and children, it is well-documented that Medicaid plays an important role filling Medicare's long-term care gap.⁴⁹ Dual eligibles made up two-thirds of all Medicaid enrollees who used long-term services in 2002.⁵⁰ While only one-third of elderly enrollees used long-term care services, this minority accounted for 86% of all Medicaid spending on seniors.⁵¹ Of this small group of 1.9 million beneficiaries, two-thirds used nursing homes, which incurred an average of \$38,780 spent per enrollee; in contrast, spending in that same year for community-based care for the other third resulted in only \$17,176 spent per enrollee.⁵² This important interaction between these two federal insurance programs illustrates another piece of the "chaotic dysfunctional patchwork" that is U.S. health care law.⁵³

CHOICE ON THE GROUND: HOW CFC FUNCTIONS

Against this national backdrop, Vermont's government recognized in 2003 that its general budget woes and the cohort of aging Baby Boomers cresting on the health care financing horizon required "wholesale changes" to the state's Medicaid long-term care program.⁵⁴ While states such as Massachusetts,

2004). Only recently has Congress amended this package to include outpatient pharmaceuticals via Medicare Part D. *Id.*

49. See *Sommers*, *supra* note 45, at 4 (noting the interplay between Medicaid and Medicare in long-term care policy). Medicaid long-term care services are also provided to the non-elderly, including younger adults and children. *Id.* at 13-15. In 2002, 406,226 children and 1.1 million adults under sixty-five received Medicaid for long-term care services. *Id.* at 2. Most children qualified for Medicaid based on income, while most adults qualified based on disability. *Id.*

50. *Id.* at 2.

51. *Id.* at 1.

52. *Id.* (indicating that 52% of Medicaid spending goes toward institutional care facilities).

53. See M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 321 (2003) (discussing health law issues, noting that "[t]he law of health care provision is a chaotic, dysfunctional patchwork.").

54. See 42 U.S.C. § 1396n (2007). Vermont sought out flexibility in this long-term care Medicaid policy making before creating CFC. Home and community-based

Minnesota, and New Hampshire responded to these same problems by clamping down on the pool of eligibles through stricter asset transfer rules, Vermont instead sought to reduce costs while enhancing consumer satisfaction.⁵⁵

In CFC, Vermont sought the federal government's approval to (1) make home and community-based services a mandatory benefit for all Medicaid enrollees needing long-term care and (2) provide limited community-based care to state residents "at risk" of needing long-term care.⁵⁶ Cost reduction features include: (1) an overall spending cap for long-term care services, (2) limitations on clinical eligibility standards, and (3) a waiting list for some categories of eligible individuals.⁵⁷

In 2004, the General Assembly of the State of Vermont enacted a bill endorsing the Section 1115 waiver request.⁵⁸ One year later, it enacted a bill implementing the federally approved waiver.⁵⁹ While each act differs in focus, they hold in common two foundational principles for how CFC should function: careful transition of those people already eligible for long-term care services and reinvestment of potential savings.⁶⁰ Both acts require DAIL to "implement the waiver in such a manner as to assure that any individual receiving services on the date the waiver becomes effective shall continue to receive *appropriate* services as assessed under the level of care criteria in effect prior to the waiver."⁶¹ Likewise, both acts explicitly state that

"[a]ny savings realized due to the implementation of the long-term care Medicaid 1115 waiver *shall* be retained by the department and reinvested into

services were made available, on a limited basis, to Medicaid enrollees under a Section 1915 waiver, which is more narrowly tailored.

55. Gene Coffey, *Vermont's Long-Term Care Waiver*, NAELA NEWS, Nov. 16, 2006, at 17, available at http://nslc.org/areas/medicaid/article.2006-11-16.9423897826/at_download/attachment (last visited Feb. 2, 2008).

56. *Id.*

57. *See id.*

58. Act Relating to Improving Availability of Home and Community Based Care Services, 2004 Vt. G.A. 123, H. 735.

59. Act Relating to Long-Term Care Waiver, 2005 Vt. G.A. 56, H. 543.

60. *See* G.A. 123, H.735 § 1(c)-(d) (Vt. 2004). *See also id.* at § 1(c)(1), (g).

61. G.A. 123, H.735 §1(c) (Vt. 2004) (emphasis added).

providing home and community based services. If at any time the agency reapplies for a Medicaid waiver to provide these services, it *shall* include a provision in the waiver that any savings shall be reinvested.”⁶²

To ensure that Vermonters on Medicaid receive appropriate long-term care, CFC uses clinical and financial screens to sort people into three levels: “Highest Need,” “High Need,” and “Moderate Need.”⁶³ To determine clinical eligibility, DAIL screens all eligible state residents with an independent living assessment.⁶⁴ To determine financial eligibility for the Highest and High Need groups, the Department for Children and Families applies its Social Security Income (SSI)-related Medicaid regulations, previously in effect under the Section 1915 waiver program.⁶⁵ DAIL applies an income standard of up to 300% of SSI and “resource eligibility” of up to \$10,000 to determine financial eligibility for the Moderate Needs group.⁶⁶

The Highest Need group is comprised of state residents who meet specific functional criteria, including those:

- 1) needing extensive or total assistance with toileting, bed mobility, eating, or transferring;
- 2) having severe impairment with decision-making or moderate impairment along with such behavioral conditions as wandering, resisting care, or physically or verbally aggressive behavior;
- 3) having conditions like end stage disease or nasogastric tube feeding which require daily skilled

62. *Id.* at §1(d). See also G.A. 56, H.543 §1(g) (Vt. 2005) (emphasis added).

63. KAISER COMM’N ON MEDICAID FACTS, THE VERMONT CHOICES FOR CARE LONG-TERM CARE PLAN: KEY PROGRAM CHANGES AND QUESTIONS 1 (2006), <http://www.kff.org/medicaid/7540.cfm> (last visited Feb. 2, 2008) [hereinafter LONG-TERM CARE PLAN].

64. *Id.* at 1; VT. AGENCY OF HUMAN SERV., DEP’T OF DISABILITIES, AGING & INDEP. LIVING, CHOICES FOR CARE 1115 LONG-TERM CARE, MEDICAID WAIVER REGS. 5 (2005) [hereinafter CHOICES FOR CARE].

65. CHOICES FOR CARE, *supra* note 64, at § IV.D.1.; LONG-TERM CARE PLAN, *supra* note 63, at 9.

66. CHOICES FOR CARE, *supra* note 64, at § IV.D.2.; LONG-TERM CARE PLAN, *supra* note 63, at 1. Enrollees may spend down to this level. *Id.* In 2006, 300% of SSI equaled \$1809 per month. *Id.*

nursing care; or

- 4) having unstable medical conditions that require daily skilled nursing care.⁶⁷

Individuals in this category are entitled to either nursing home or home and community-based services.⁶⁸

The High Need group consists of Vermont Medicaid recipients who do not meet the first group's eligibility requirements, but who have extensive need for personal care and rehabilitation services.⁶⁹ Enrollees in this category are eligible for either nursing home or home and community-based services.⁷⁰ They are not, however, entitled to long-term care services, but instead have access to them under the waiver program as funds become available.⁷¹ Many of these people had received services through a previous Section 1915 waiver program, so they are now automatically enrolled into the Section 1115 program. In contrast, state enrollees who were not previously in the Section 1915 waiver program receive long-term care services subject to resource availability.⁷²

The Moderate Need group consists of state residents who do not currently qualify for institutional care under the needs assessment criteria, but who may in the near future.⁷³ Eligibility criteria for this category include residents:

1. needing supervision or physical assistance more than three times in a week,
2. having impaired judgment which requires general supervision,

67. CHOICES FOR CARE, *supra* note 64, at § IV.B.1.b (i-iv).

68. CHOICES FOR CARE, *supra* note 64, at § VIII.A; LONG-TERM CARE PLAN, *supra* note 63, at 1.

69. See CHOICES FOR CARE, *supra* note 64, at § IV.B.2.b (i-vii); LONG-TERM CARE PLAN, *supra* note 63, at 1.

70. CHOICES FOR CARE, *supra* note 64, at § VIII.B; LONG-TERM CARE PLAN, *supra* note 63, at 1.

71. See CHOICES FOR CARE, *supra* note 64, at § V.D.2; LONG-TERM CARE PLAN, *supra* note 63, at 1.

72. See generally LONG-TERM CARE PLAN, *supra* note 63.

73. CHOICES FOR CARE, *supra* note 64, at § IV.B.3.b (i-iv); see CHOICES FOR CARE, *supra* note 65, at 8 (describing individuals who may qualify as having "moderate needs").

3. requiring monitoring for a chronic health condition at least monthly, or
4. having a health condition which would worsen without services.⁷⁴

This group is a new, expansion population not previously served by the Vermont Medicaid long-term care program. Individuals in this category are not eligible for nursing home care, only home and community-based services.⁷⁵ Importantly, the Moderate Need group is not entitled to care, but rather may receive it as funds allow.⁷⁶ At the moment, a designated “set aside” fund pays for this group’s services.⁷⁷

Currently, CFC includes all long-term care services users covered by Vermont’s Medicaid budget.⁷⁸ The Section 1115 waiver program covers all eligibles in nursing homes,⁷⁹ in the home and community-based services program established in the previous Section 1915 program,⁸⁰ in the Enhanced Residential Care (ERC) waiver program,⁸¹ and in the new Program for All-Inclusive Care for the Elderly (PACE).⁸² CFC operates under a five-year global budget cap of \$1.236 billion imposed by the federal government.⁸³ This upper limit is based on projections of the demand for long-term services by Vermont’s low-income elderly and individuals with disabilities.⁸⁴ If actual costs exceed the cap, Vermont policymakers will face the difficult choice of

74. CHOICES FOR CARE, *supra* note 64, at § IV.B.3.b (i-iv).

75. CHOICES FOR CARE, *supra* note 64, at VIII.B.

76. *See* CHOICES FOR CARE, *supra* note 64, at § V.3.

77. CHOICES FOR CARE, *supra* note 64, at § IV.C.

78. *See* CHOICES FOR CARE, *supra* note 64, at 9.

79. *Id.*

80. *Id.* at 5.

81. ERC “means a package of services provided to individuals residing in a licensed Residential Care Home that has been approved to provide these services. CHOICES FOR CARE, *supra* note 64, at § III.19.

82. PACE “means a combination of medical, acute, and long-term care services provided to individuals aged 55 and over by an approved PACE provider.” CHOICES FOR CARE, *supra* note 64, at § III.40. *See also* WASSERMAN, *supra* note 31, at viii (noting that the PACE program targets frail seniors and currently operates in only two locations).

83. LONG-TERM CARE PLAN, *supra* note 63, at 1-2.

84. *Id.* at 2.

funding them out of state revenues or limiting service provision to stay under the cap.⁸⁵ At the time the waiver was granted, the state anticipated saving \$61 million by moving existing service recipients to community-based care. It planned to use \$56 million of this savings for services for the High Need and Moderate Need groups.⁸⁶

IS THE SHIP REALLY TURNING AROUND? CFC'S PERFORMANCE IN ITS FIRST TWO YEARS

Enrollment figures from the first year indicate that Vermont moved decisively toward achieving its goal of making long-term care services available to more state residents.⁸⁷ As the table in Figure 1 shows, 700 additional Vermonters received long-term care services by June 2006, a 22% increase in overall enrollment. There was sufficient funding to provide care to almost 450 members of the Moderate Need group, who were previously not entitled to care.⁸⁸ In addition, members of the Highest Need and High Need groups saw an 8% increase in enrollment.⁸⁹

In contrast, Vermont experienced mixed first-year results in achieving its goal of changing Medicaid's institutional bias toward long-term care services. Despite the stated goal of moving enrollees from nursing homes into home-based care, there was actually a modest increase of 2% in nursing home patients by June 2006.⁹⁰ Home and community-based service recipients, however, increased by 15%, and enhanced residential care recipients increased by a whopping 50%.⁹¹

Two years of data more strongly indicate that Vermont has begun turning its own institutional bias ship around. In the last year, the number of Medicaid recipients receiving services in

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id.*; See Appx. Figure 1.

89. *Id.*

90. *Id.*

91. *Id.*

home and community-based settings increased by almost 300, or about 20%, the largest increase ever.⁹² In addition, the number of CFC enrollees receiving long-term care in an institutional setting declined by 250 between October 2005 and October 2007.⁹³ Some of these enrollees transitioned into enhanced residential care settings, while others went into home and community-based services.⁹⁴ Regardless of the non-institutional setting in which they ended up, the one they left felt the impact: during this same two-year period, nursing home capacity in Vermont decreased by 140 beds.⁹⁵ As the line graph in Figure 3 suggests, these twin trends of declining enrollment in nursing homes and increasing use of home and community-based settings will continue under the CFC entitlement structure.⁹⁶

In its first two years, CFC appears to have achieved its first two goals of increasing the use of home and community-based care and decreasing the use of nursing homes. However, statistics from October 2007 indicate that the third stated goal of lowering overall spending on long-term care has not yet been attained.⁹⁷ Instead, as the graph in Figure 4 illustrates, Medicaid expenditures have continued to rise, with an overall increase of \$30 million in both nursing home and community settings since 2000.⁹⁸

What about the theory that decreased use of institutional care would result in cost savings that would not be eclipsed by increased use of lesser-cost community-based services? As of 2007, 70% of CFC expenditures went to nursing homes even though only 55% of the Highest Need and High Need enrollees

92. HILL, *supra* note 37, at 1. Notably, this positive experience has not been hampered by a sudden increase in enrollee numbers that would cause an unsustainable cost increase. *Id.* at 13. See Appx. Figure 2.

93. *Id.* at 3.

94. *Id.*

95. *Id.*

96. See *id.* at 3. See also *id.* at 14-19 (noting that the approaches taken by individual counties vary, and while the state-wide trend is toward home and community-based care, some counties still largely deliver institutional care). See Appx. Figure 3.

97. *Id.* at 22.

98. *Id.* at 22-24. See Appx. Figure 4.

opted for nursing home services.⁹⁹ In contrast, 30% of CFC expenditures went to home and community-based services and enhanced residential care services, even though 45% of the Highest Need and High Need enrollees are served in these settings.¹⁰⁰ Nursing home expenses have increased by about 3%¹⁰¹ while home and community-based services expenses have increased by 40%, and enhanced residential care by about 80%.¹⁰² Variable uses of these services by county suggests some room for more movement away from the institutional setting and possibly some additional savings, but it is not clear how much this transition would contribute to achieving the overall goal of decreasing the state's overall Medicaid spending on long-term care.

In the end, the ultimate way to measure the quality and sustainability of a long-term care system is to ask whether it provides a continuum of services in settings ranging from the home to the nursing home, so that individuals receive care in the most clinically appropriate and cost-effective setting. At this level, CFC appears to be a resounding success. The state pays for services provided in an array of long-term care service settings, and an increasing number of Vermont elders are eligible to receive them under Medicaid.¹⁰³ Moreover, as the bar graph in Figure 6 suggests, participation rates in the various programs indicate that the most intensive service settings are being used by the oldest, and arguably most medically needy,

99. *Id.* at 23.

100. *Id.*

101. *Id.* These services have a statewide average cost of \$3,488 per plan of care. *Id.* at 32. Notably, home and community-based care costs vary widely by county due to such factors as the degree of reliance on unpaid caregiving, varying use of home health agency services instead of consumer or surrogate-directed services, the number of personal care hours authorized, higher usage of adult day care services, and use of other payor sources for home health services. *Id.*

102. *Id.* at 23. See *id.* at 33 (noting that enhanced residential care (ERC) services have a statewide average cost of \$2,165 per plan of care, or 40% less than the cost of home-based care. The range of ERC service costs are smaller than that for HCBS care, given that adult day care services are not included and that plans are based on reimbursement tiers that do not represent a specific number of hours of personal care). See also Appx. Figure 5.

103. LONG-TERM CARE PLAN, *supra* note 63.

state residents.¹⁰⁴

While there is no available data to assess the fairness of the screening process used to determine which enrollees are deemed Highest Need and High Need,¹⁰⁵ the first two years of directing CFC enrollees into a long-term care setting does not show obvious anomalies. In this way, the experience to date would seem to agree with the observation that "Vermont's approach clearly is a more enlightened approach and broadens the dialog about possible methods of modifying health care approaches."¹⁰⁶

What is less clear is CFC's long-term impact on the provider community, especially nursing homes and home health care agencies. The stated goal of reducing the number of nursing homes has already been met with the net reduction of 140 beds in the first two years.¹⁰⁷ While it was never envisioned that nursing homes would completely disappear, despite Commissioner Flood's characterization of them as outdated models, the state certainly imagines them changing as the CFC experiment continues.¹⁰⁸ Notably, the Vermont legislature created a Task Force on the Sustainability of Nursing Homes in the act implementing CFC to help the DAIL Commissioner develop statewide recommendations on the future of Vermont's nursing homes.¹⁰⁹ It was legislatively directed to consider such questions as:

the transition issues for nursing homes as more individuals use home- and community-based long-term care services, how nursing homes can convert the services offered to provide long-term care services differently, unmet needs for nursing home services for

104. HILL, *supra* note 37, at 26. See Appx. Figure 6.

105. Notably there were two long-term care ombudsmen positions created to play the "watchdog" role over the waiver program, which are required to report complaints to the legislature each year. See Act Relating to Long-Term Care Waiver, 2005 Vt. G.A. 56, H. 543, available at <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/bills/passed/H-543.htm>; VT. STAT. ANN. TIT. 33, §7503(10) (Westlaw current through Feb. 2, 2008).

106. Coffey, *supra* note 55, at 20.

107. HILL, *supra* note 37, at 3.

108. See, e.g., H.B. 543 § 1a (Vt. 2005).

109. *Id.*

individuals, accessibility for individuals with disabilities in nursing homes, and the methods which nursing homes can use to become more resident-centered¹¹⁰

The jury is still out on these questions. Likewise, although the first two years of experience show a continued trend in rising costs for nursing home care,¹¹¹ the data is unclear about the reasons for it. One hypothesis is that rising patient acuity is fueling this increase, because as healthier elders seek home and community-based care, sicker patients require more intensive institutional services.

In contrast to documented concerns about CFC's effect on nursing homes, relatively few problems were anticipated with home health care providers.¹¹² Given the emphasis on home-based care, one would have anticipated a boom in home health agency Medicaid revenues. In fact, the opposite has occurred: in fiscal year 2006, the Vermont Assembly of Home Health Agencies reported almost \$2 million in losses on about \$12 million of CFC revenues.¹¹³

One reason for this loss could be the lack of fit between the agencies' cost structure and CFC reimbursement rates, which have been set for "consumer-directed" care. Recall the \$9.27 per hour paid to Mr. Blow's ex-wife. With higher overhead due primarily to the cost of complying with various governmental regulations, home health agencies like the non-profit Visiting Nurse Associations are at a competitive disadvantage. In the long-term, CFC could change the shape of the state's home health care industry, for these agencies cannot underwrite chronic Medicaid losses with surpluses garnered from other payors, especially as Congress lowers Medicare reimbursement rates.¹¹⁴

110. *Id.*

111. See HILL, *supra* note 37, at 22.

112. See, e.g., H.B. 543 § 1a (Vt. 2005).

113. VT. ASSEMBLY OF HOME HEALTH AGENCIES, VERMONT MEDICAID/DAIL HOME CARE PAYMENTS – FY 2006 (2006) (on file with author).

114. NAT'L HOME CARE AND HOSPICE, HEALTH CARE ACCESS PROTECTION ACT OF 2007 (2007), available at http://www.congressweb.com/nahc/docfiles/Fact_Sheet_

Probably most importantly, whether CFC can truly pave a way away from Medicaid's traditional institutional bias in long-term care appears to largely depend on whether Vermont's current supply of home care helpers will hold out. Currently, no data suggests that the numbers have dwindled. Given the relatively low amount of industrialization and paucity of high-wage jobs, Vermont's labor supply of \$10 per hour home care workers appears elastic. Still, the question remains whether this capacity is available in other states, especially in light of the broader demographic trend of a declining younger population with increasing geographic mobility. These population trends strongly suggest that a model built on young caregivers will have difficulty sustaining itself.¹¹⁵

"BUILD IT AND THEY WILL COME"¹¹⁶

Traditional Medicaid gave clear incentives to build and staff nursing homes. Now, the newly constructed entitlement in Vermont's CFC builds home and community-based structures that are more self-directed and thus harder to assess and regulate. The data to determine whether CFC provides a role model for rebuilding long-term care services across the United States are still preliminary, but hold promise. After two years, one can unequivocally conclude that CFC is delivering long-term care in home and community-based settings to a greater proportion of Vermont's Medicaid recipients. This upward trend is predicted to continue, while the proportion of state

HR_3865_and_S_2181_Oct_07.pdf (last visited Feb. 2, 2008). See Congresswoman Kelly Bill Recognizes Necessity For Full Medicare Update For Home Health Agencies, MEDICAL NEWS TODAY, Oct. 19, 2006, <http://www.medicalnews today.com/articles/54484.php> (last visited Feb. 2, 2008) (discussing how Congresswoman Sue Kelly of New York is introducing a Congressional resolution that would recognize the need for home health agencies to receive their full updates to help them respond to higher care and operations costs).

115. This is clearly a concern that Vermont policymakers are tracking closely. Two recent studies on the topic recommend annual inflationary increases. DAIL is currently working on an in-depth study of current wages and benefits. WASSERMAN, *supra* note 31, at iv.

116. FIELD OF DREAMS (Gordon Co. 1989).

residents cared for in nursing homes is predicted to decline. In addition, the program has had enough funding to provide home and community-based care to an expansion group of less clinically needy patients, anticipating that these services will diminish the need for institutional care in the short and long-terms. These results merit emulation.

But other data from this two-year experiment point to several open questions, which will require more time to answer. CFC is reshaping the landscape of long-term care providers, with resulting industry effects both intended, on nursing homes, and unintended, on home health agencies.¹¹⁷ Moreover, the initial success in shifting care away from institutions does not provide a clear answer to the cost trade-off between nursing home and home and community-based care.¹¹⁸ To date, Vermont has not shown that CFC has solved the overall long-term care spending problem.¹¹⁹ Likewise, the question of whether expanding home and community-based services for those on the eligibility edge successfully staves off their eventual admission to a nursing home is still an open one. Finally, the demographic question about the home care provider pool underlines the fact that the experience of CFC, as a very small¹²⁰ state experiment, might be hard to replicate in other states.

The clear result of this "novel social and economic experiment"¹²¹ is that states with Section 1115 waivers become Medicaid policymakers, in fact at the cutting edge of Medicaid policy design. At some level, this may seem like a proper recalibration¹²² of the state-federal partnership that is Medicaid.

117. See, e.g., S. 2181, 110th Cong. (2007).

118. See HILL, *supra* note 37 at 22.

119. *Id.*

120. GUYER, *supra* note 34, at 5 (Vermont's Medicaid program accounts for less than one percent (0.28%) of all Medicaid spending nationwide).

121. See *supra* note 20 and accompanying text.

122. Vermont Long-Term Care Plan Fact Sheet, http://www.nslc.org/areas/medicaid/article.2006-11-16.8066299734/at_download/attachment (last visited Jan. 23, 2008) (CMS uses the phrase "rebalancing": "The Vermont Long-Term Care Plan, a section 1115 demonstration, is a statewide initiative to rebalance long-term care services through managing nursing facility admissions and increasing community-based options.") *Id.*

Certainly in the long-term care arena, no one would debate that Medicaid's historical focus on delivering service in nursing homes was short-sighted, at best. It seems likely that in this era of federalism, few would debate the premise that states are better equipped to understand its population's needs and the local sensibility for meeting them.

In the spirit of Justice Brandeis' famous quote, experimenting with long-term care benefit design in Vermont "without risk to the rest of the country," and then applying the lessons learned to the overall Medicaid program, would seem a happy marriage of state and federal form and function.¹²³ From this vantage point, Vermont's CFC experiment certainly provides excellent anecdotal and analytical information on both utilization and cost, to "pave the way" for other states.¹²⁴ And given the federal cap, Vermont's decision to seek ways to expand the reach of Medicaid's long-term care entitlement in the face of state financial risk shows the kind of courage that Justice Brandeis envisioned.

But is it possible that, while experimenting to meet consumer service demands and state administrative flexibility desires, we might also be quietly moving away from the federal nature of the Medicaid entitlement? CMS's approval letter to Vermont officials provides a subtle clue: "Experience gained through this demonstration may pave the way *for other states* seeking to reduce the institutional bias of Medicaid."¹²⁵ By these very words, CMS appears to posit a struggle between state and federal Medicaid partners, where states actively seek to reduce the federal government's "institutional bias."

This antagonism plays out in other, related ways. For example, while Vermont's CFC and Global Commitment programs genuinely seek to improve the quality and efficiency of Medicaid services for its residents, state policymakers do not attempt to hide the attraction of having their own, final say on

123. See *supra* note 20 and accompanying text.

124. See Approval Letter, *supra* note 5.

125. *Id.*(emphasis added).

benefit design.¹²⁶ Likewise, state officials enjoy the spending autonomy of a Section 1115 block grant more than the traditional position of receiving matching grants doled out by federal government.¹²⁷

But what if, in the next few years, this aging state spurs long-term care service demands that exceed the capped funds? Vermont would then have to make the hard choice between narrowing eligibility and expanding the use of state tax revenues. To cut back on eligibility means compromising on the belief that providing home and community-based services is the best way to provide long-term care to Vermont's elders. To raise more state funds via taxes means recognizing that the federal Medicaid "match" was insufficient to sustain this method of care delivery and asking state taxpayers for more.

Regardless of the ultimate choice, the need to make it underscores the fact that states like Vermont have been put in the driver's seat of Medicaid policymaking. Federal waivers are intended to try out innovations at a smaller-than-national level, to permit CMS to learn how to design a better *federal* entitlement without putting the entire program in jeopardy.¹²⁸ If, however, the results of CFC only pave the way for other states to individually redesign their long-term care entitlement, then Medicaid's federal nature is called into question.

In this fashion, the state experiment, while intended to strengthen the quality and expand the breadth of long-term care

126. See, e.g., GUYER, *supra* note 34, at 1 (noting that Governor Douglas stated that the state sought the Global Commitment waiver because of "state fiscal problems and the desire for more flexibility to change the Medicaid program without federal review.").

127. In the case of the CFC section 1115 waiver, Vermont officials seek to use excess funds left after treating the highest need and high need groups to expand service to treat the moderate need group, thereby using Medicaid funds to serve the health care needs of low income residents. See LONG-TERM CARE PLAN, *supra* note 63, at 1-2. In contrast, the Global Commitment Section 1115 waiver provides the state with discretion to use a portion of the Medicaid block fund for non-Medicaid health spending. GUYER, *supra* note 34, at 2 (noting that Vermont has already identified fifty different programs which may use the excess funds, including "tobacco cessation programs, domestic violence initiatives, and the state's medical school and public laboratory.").

128. See 42 U.S.C. § 1315.

service design, risks weakening the sense and limiting the depth of federal responsibility for it. Certainly, this result is more subtle and hazy on the horizon, compared to many states' current budget woes in the face of increased Medicaid spending on long-term care. Vermont made a courageous choice to tackle its shortfalls by shifting the locus of care and providing more of it, not less, despite clear financial risk shifting from the federal government. Hopefully, as the results of CFC become clearer over the next two years, the federal government will make a similar, courageous choice to permit all Medicaid recipients to benefit from this long-term care redesign.

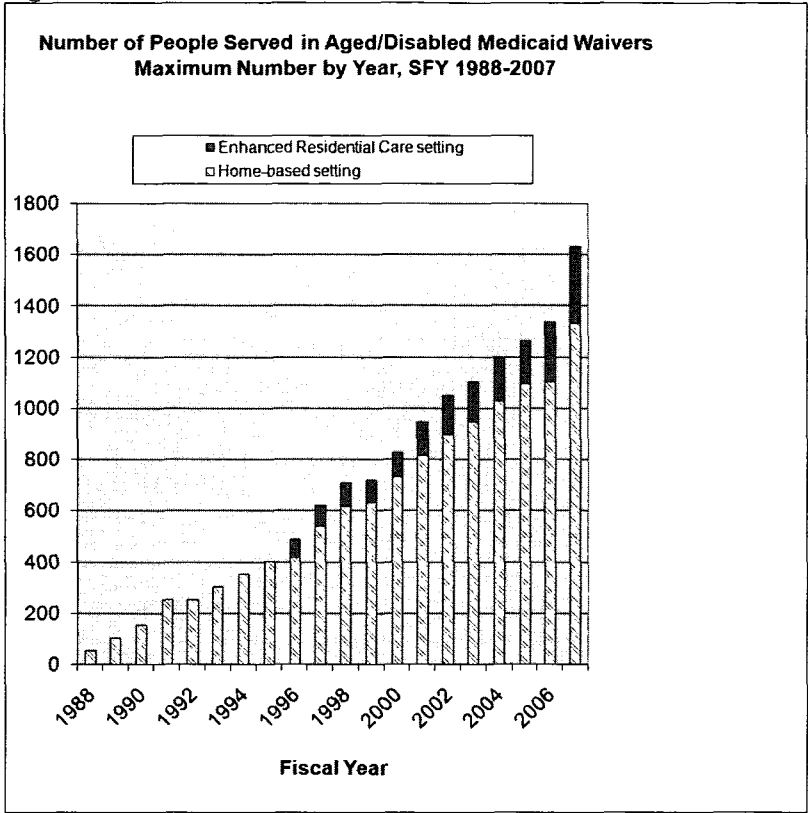
APPENDIX

Figure 1.¹²⁹

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

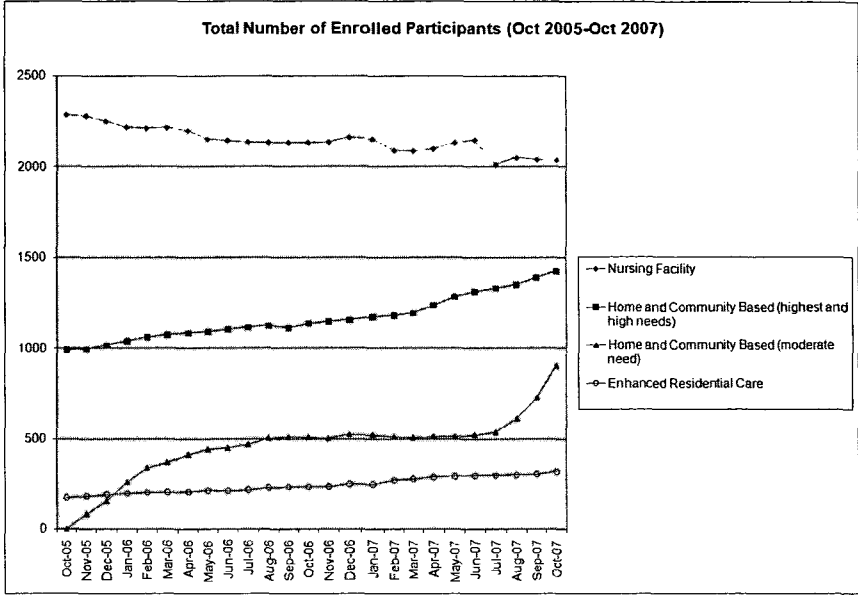
129. LONG-TERM CARE PLAN, *supra* note 63, at 2.

Figure 2.¹³⁰



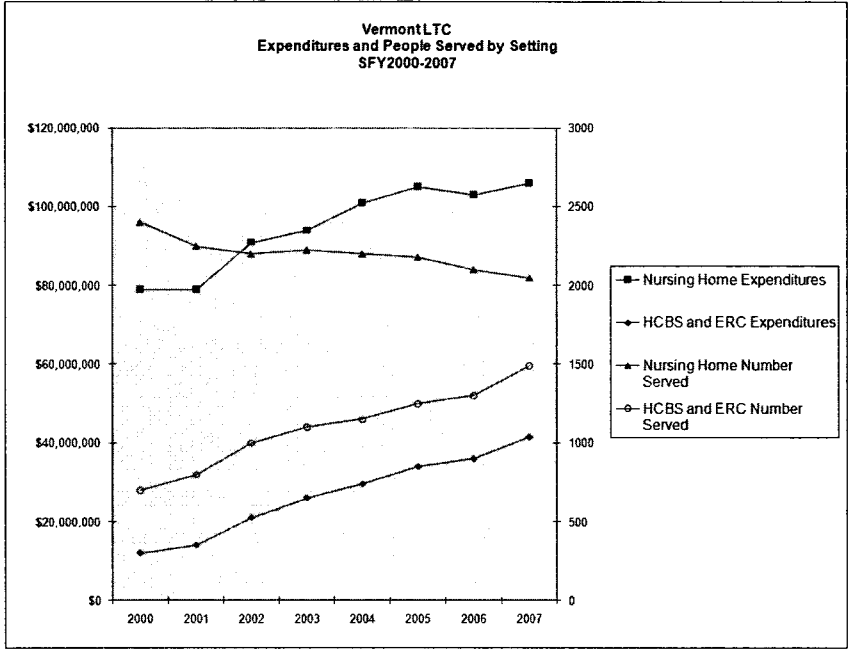
130. HILL, *supra* note 37, at 1.

Figure 3.¹³¹

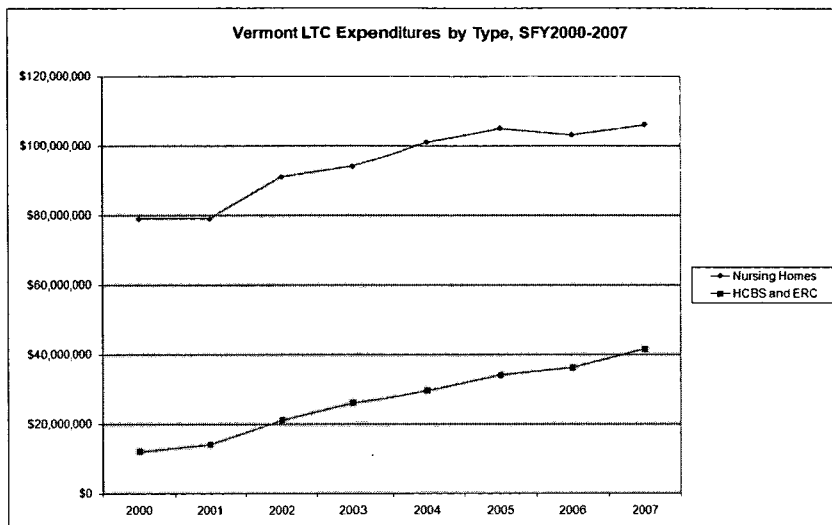


131. HILL, *supra* note 37, at 3.

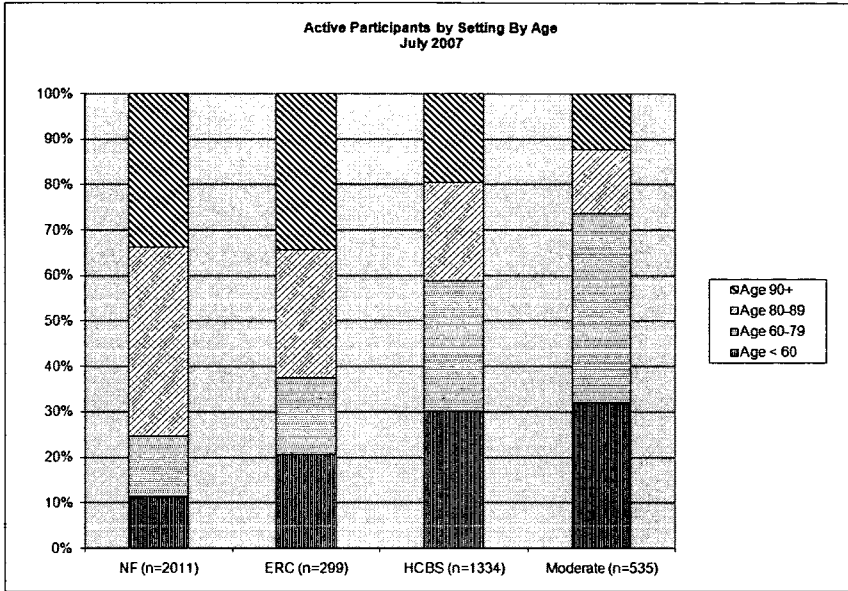
Figure 4.¹³²



132. HILL, *supra* note 37, at 24.

Figure 5.¹³³

133. HILL, *supra* note 37, at 24.

Figure 6.¹³⁴

134. Hill, *supra* note 37, at 24.
