



ACT 160 OVERVIEW

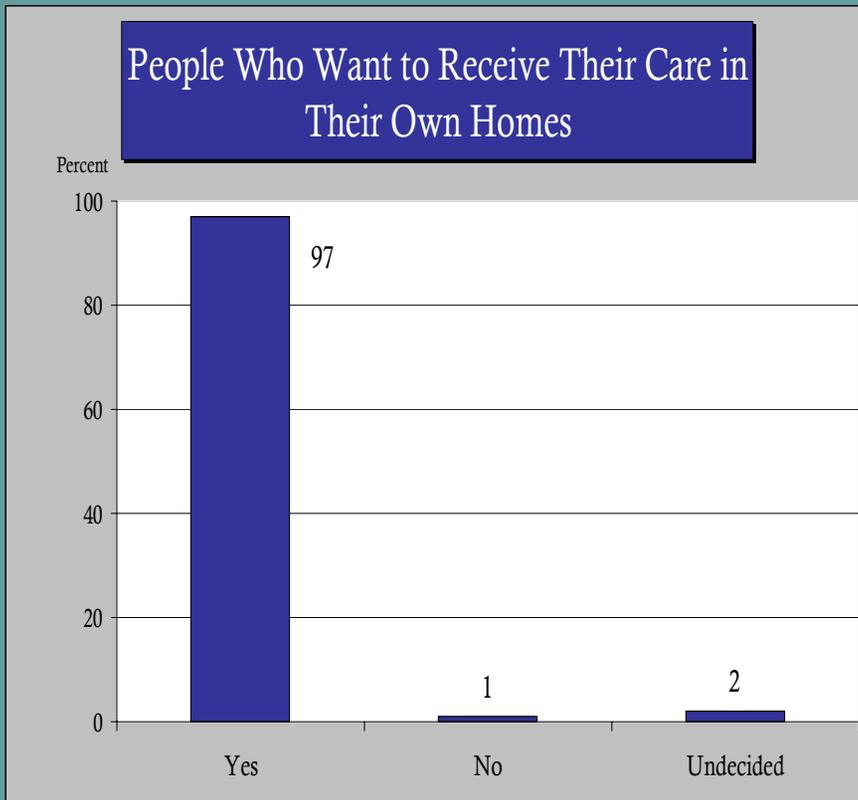


Vermont Agency Of Human Services
Department of Aging & Disabilities

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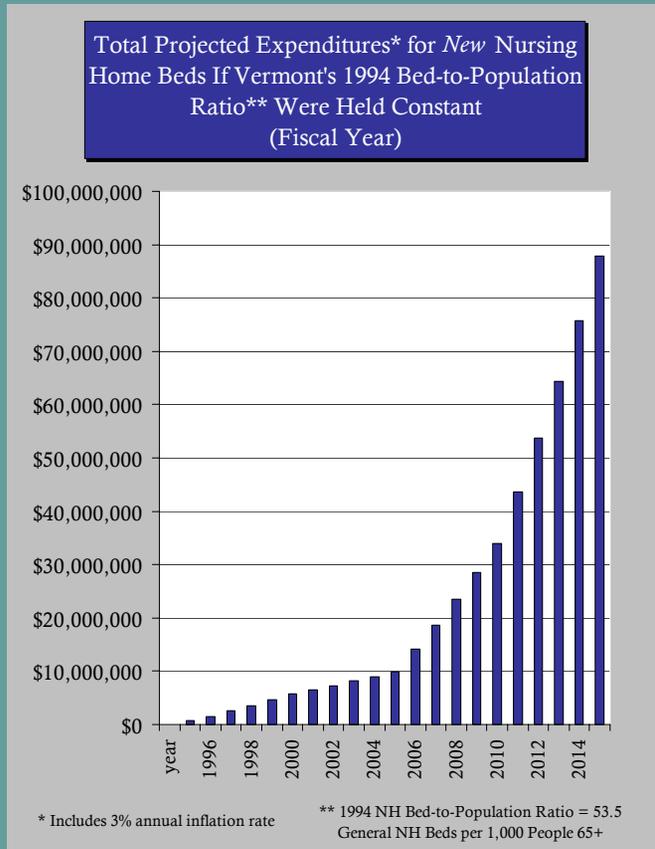


OLDER VERMONTERS' PREFERENCES FOR LONG TERM CARE



The vast majority of long-term care is provided by family, friends and neighbors to people living at home. In a 1994 survey of Vermonters conducted by AARP, over 95% of Vermonters stated that they wanted to receive their care at home as opposed to in an institutional setting.

A GLIMPSE AT AN UNTENABLE FUTURE



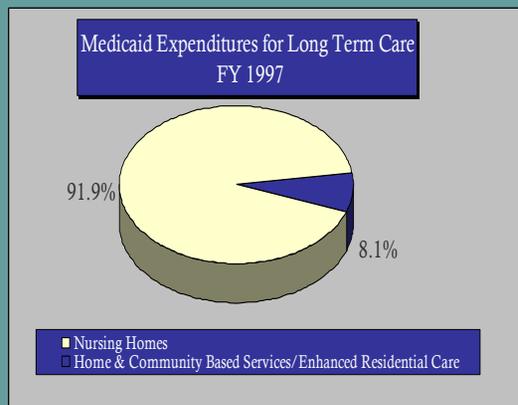
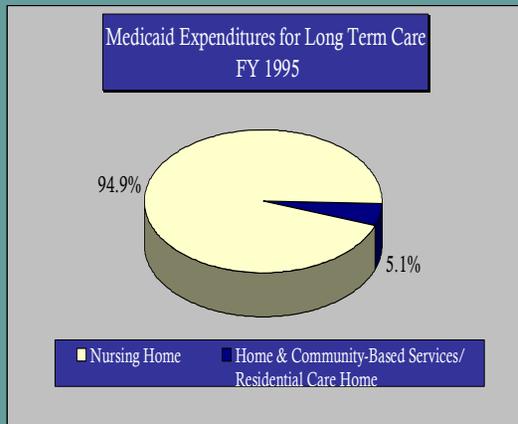
- Public funding has not reflected this basis preference.
- The State of Vermont will be unable to afford the care needed by both older people and younger adults with physical disabilities unless we prepare for the future by building a strong community-based system of care which honors and respects consumers' dignity and independence.

ACT 160 IS ENACTED

Act 160, passed on May 5, 1996, requires Vermont's Agency of Human Services (AHS) to:

- *improve the state's independent living options for vulnerable elders and younger people with physical disabilities;*
- *create a climate where Vermonters may live in the most independent, least restrictive environments they choose;*
- *slow the growth of its Medicaid nursing home budget; and*
- *redirect these dollars into home and community-based services, with "consumer participation and oversight...in the planning and delivery of long-term care services."*

THE SHIFT BEGINS



- In 1995, the public funds used to purchase long-term care services were spent primarily on institutionally-based care delivered in nursing homes.
- Since the inception of Act 160, public funding for home and community-based services and residential care has increased from 5.1% to 8.1%. This shift is a significant step in moving towards a more equitable system that reflects consumer preferences.

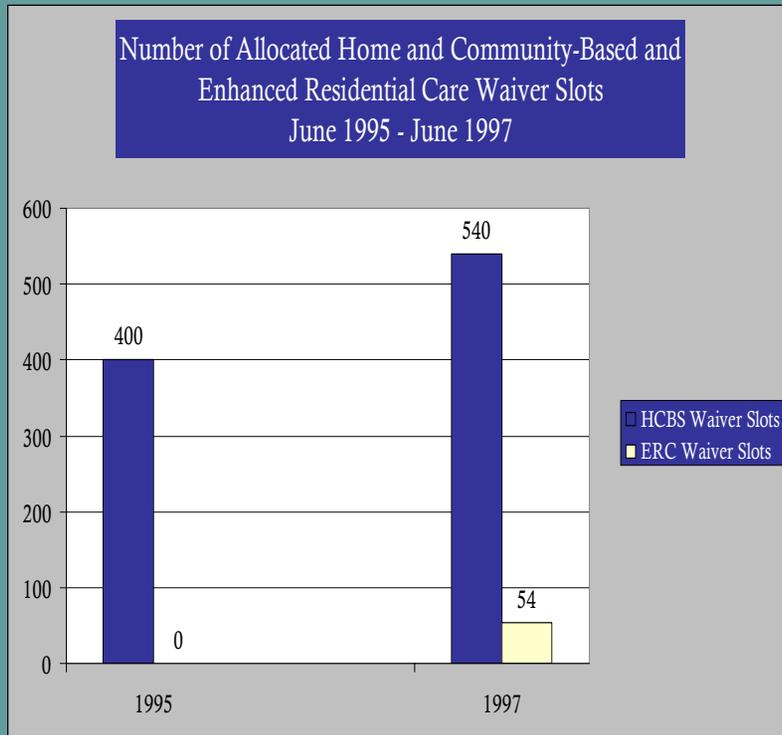
NURSING HOME OCCUPANCY DECLINES

Vermont Nursing Facility Occupancy
1994-1997



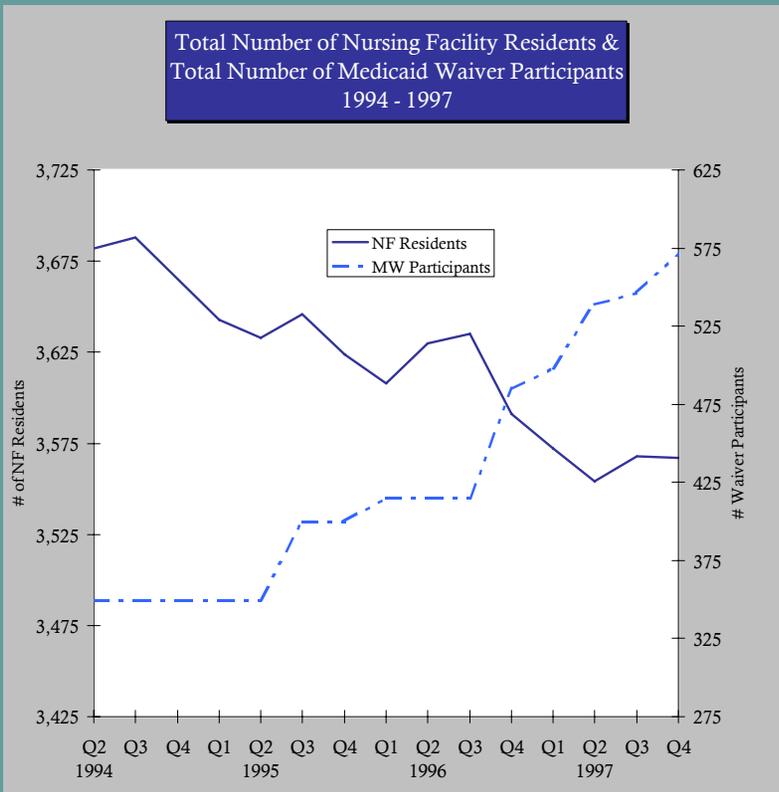
- In 1996, Vermont had the fourth highest nursing home occupancy rate in the nation*
- In the last three years, nursing home occupancy has declined 2.6 percent, from 96.68% to 94.08%.

MORE CONSUMERS ARE SERVED IN THE COMMUNITY



With a 35% increase in home and community-based waiver slots and the implementation of the new Enhanced Residential Care Home waiver in 1996, more consumers are able to receive services and live with dignity and independence in the environments they prefer.

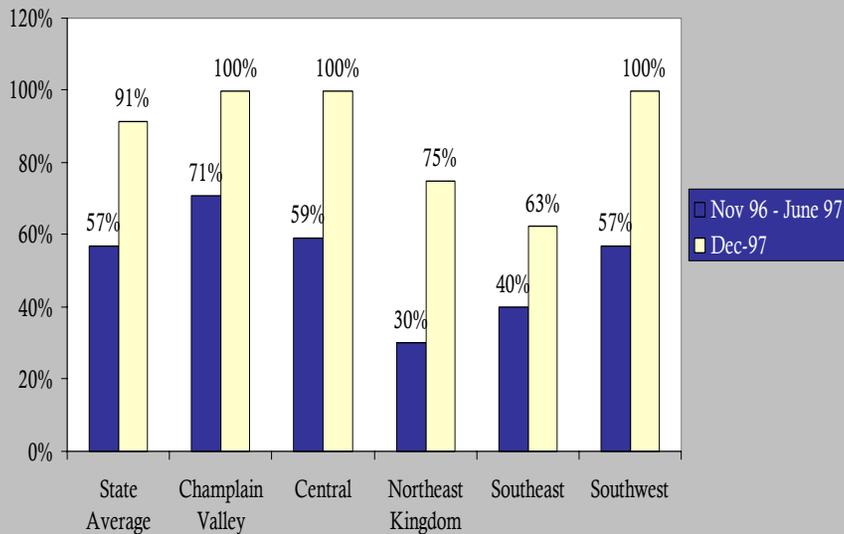
CONSUMERS ARE MAKING THEIR PREFERENCES KNOWN



From calendar years 1994 - 1997, the number of persons residing in nursing homes decreased by 3.2%, and the number of persons served by the Home and Community-Based Waiver Program increased by 54%. With more community options available, consumers will have more choice to live in the environments they prefer.

MORE PEOPLE WHO ARE AT IMMEDIATE RISK OF NURSING HOME PLACEMENT ARE BEING SERVED IN THE COMMUNITY

Priority Admissions* to Home-Based Medicaid Waiver
November - June 1997 Compared to December 1997



Prioritization of the home-based Medicaid waiver program began in November 1996. Within a 14-month period, priority admissions to the program have, on average, increased by 34%.

NURSING HOME RATES AND REIMBURSEMENT



- While nursing home occupancy continues to decline, nursing home rates continue to grow.
- As Act 160 unfolds, current rate setting regulations are scheduled to sunset in June of this year.
- The revised system, developed by the Center for Health Policy Studies, representatives from AHS, and the nursing home industry, will allow for continuous growth of nursing home payment rates to assure quality care.

WHY ELIMINATE “RETURN ON EQUITY”

- *ROE is obsolete, a vestige of a different era*
 - Even though a moratorium on new nursing home construction has been in effect since 1993, the ROE subsidy still lives on. With the enactment of Act 160, Vermont resolved to reduce the supply of nursing home beds, as citizens prefer to receive long-term care services in their own homes. In this new environment, ROE is obsolete. Vermont must now focus its attention on investing in other, less costly models of long-term care.
- *None of the other long-term care providers receive the ROE subsidy*
 - Elimination of ROE takes one more step in the direction of treating long-term care providers more equally: non-profit nursing homes, hospitals, adult day care centers - none of which receive return on equity.
- *Federal Medicare does not pay ROE*
 - According to federal law, Medicare does not pay ROE.
- *Most states do not pay an ROE subsidy*
 - 70% of the states surveyed do not include ROE in the Medicaid reimbursement programs.

WHY REPLACE THE “EFFICIENCY INCENTIVE” WITH A “QUALITY INCENTIVE”

- *The so-called Efficiency Incentive was never really an “incentive”*
 - The Efficiency Incentive was not an effective inducement for nursing homes to change their behavior. There is no evidence to suggest that nursing homes attempted to become more efficient in order to qualify for the incentive payments. In general, the same nursing homes who initially qualified for the Efficiency Incentive are the ones receiving it today.
- *Creating a Quality Incentive advances the purpose of OBRA ‘87*
 - Reallocating money from the Efficiency Incentive to a new Quality Incentive rewards the nursing home industry for further improving the quality of care provided to residents.
- *Funding for the incentive pool stays in the nursing home reimbursement system*
 - Replacing the Efficiency Incentive with a Quality Incentive assures the nursing home industry that the funds allocated for the incentive pool will still be available to nursing homes.

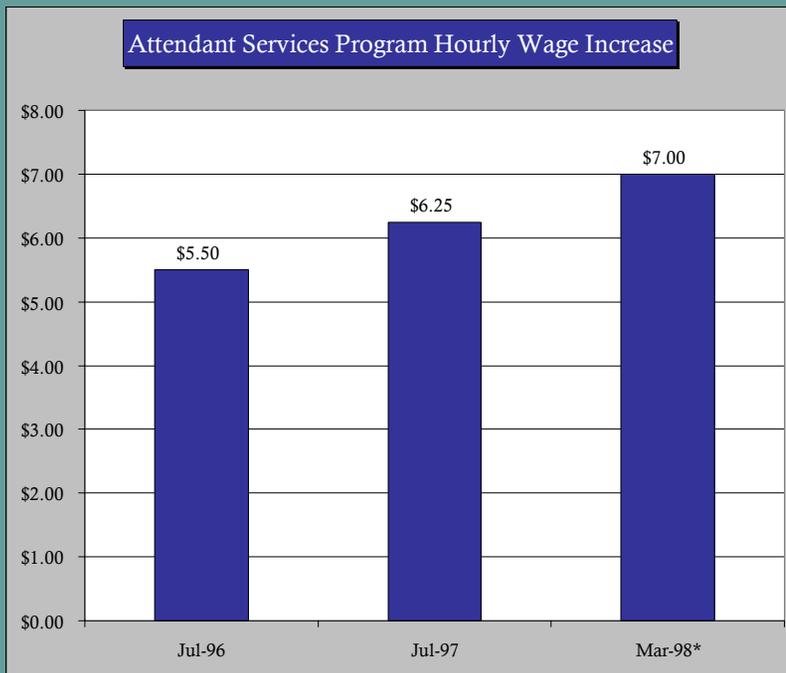
WHY COUNT ONLY MEDICAID RESIDENTS WHEN CALCULATING A NURSING HOME'S CASE MIX REIMBURSEMENT?

- *Other payors consider only their own residents when reimbursing nursing homes*
 - For example, the federal Medicare system only includes its own Medicare residents when calculating a nursing home's Medicare reimbursement.
- *Most other states count only the Medicaid population when computing casemix*
 - 65% of the states surveyed include only Medicaid residents when calculating a facility's casemix score for purposes of Medicaid reimbursement.
- *Counting non-Medicaid residents artificially inflates the acuity and overstates the medical needs of the Medicaid population*
 - Residents with other payor sources, such as Medicare and private insurance, usually require more skilled care and rehabilitation than the general Medicaid population. Including these higher care residents in the casemix calculation exaggerates the medical needs of the Medicaid population, resulting in a reimbursement rate higher than necessary to care for the real medical needs of the Medicaid population.

WHY COUNT ONLY THE MEDICAID RESIDENTS CONTINUED

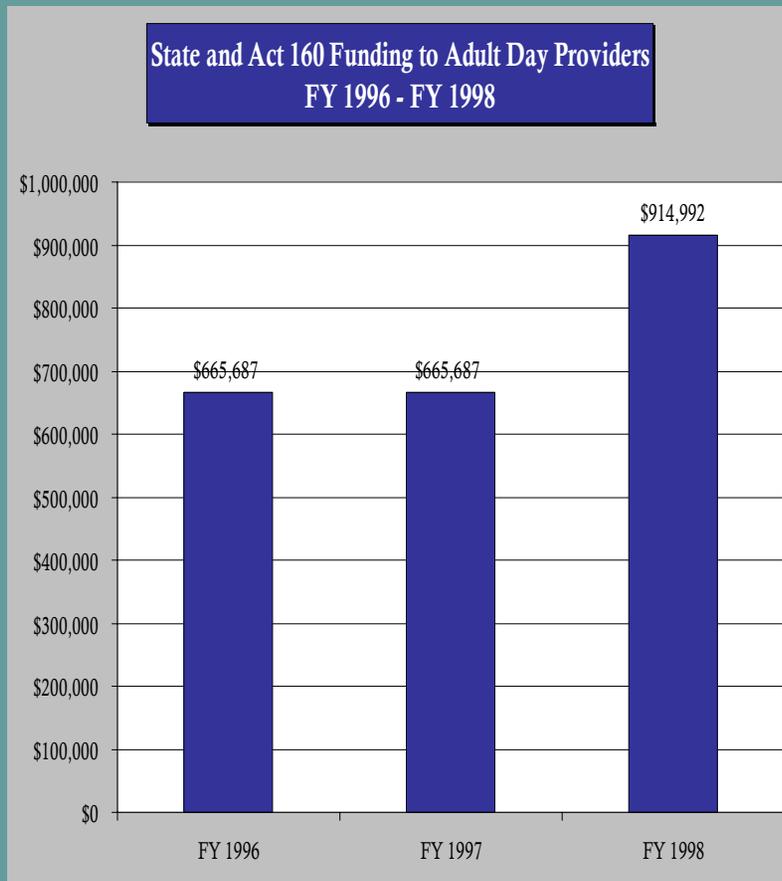
- *Converting to a Medicaid-only casemix calculation will not change nursing home admission practices*
 - Since Medicaid represents 65% of the population in most Vermont nursing homes, the industry still has a powerful incentive to continue admitting high casemix Medicaid residents.
- *Adopting a Medicaid-only casemix calculation will not change the quality of care provided to Medicaid residents in nursing home*
 - The federal Nursing Home Reform Act (OBRA '87) and Vermont's own nursing home regulations prohibit nursing homes from discriminating in the quality of care provided to residents based on payor source. Every resident is entitled to receive the same level of care.
- *Nursing homes which have increased their participation in the Medicare program will be rewarded as Medicare shifts to a prospective payment system*
 - Both the federal government and nursing home industry sources report that reimbursement rates for Vermont nursing homes will rise significantly under the new Medicare PPS reimbursement system.

REIMBURSEMENT TO COMMUNITY-BASED PROVIDERS INCREASES



- From 1989 through 1996, attendants received no wage increases.
- In response to the inflationary erosion in the value of caregiver wages, the Vermont legislature increased funding to support an increase in these wages.
- In March 1998*, wages paid to caregivers that have been employed for 6 months or longer increased from \$6.25 per hour to \$7.00 per hour.

RATE INCREASE AND PROGRAM EXPANSION DOLLARS HELP ADULT DAY PROVIDERS



- Act 160 has generated many of the expansions and enhancement of services within adult day programs.
- An additional \$250,000 was invested in adult day in FY98 which increased funding by 37%.
- 30% of adult day providers now operate 5 days per week, between the hours of 9am and 5pm.
- Eight providers are expanding the scope of services to include both social and medical models of care.

BUILDING THE COMMUNITY-BASED LONG-TERM CARE SYSTEM

- \$50,000 was awarded to the Champlain Valley Agency on Aging to develop a pilot respite program for individuals with Alzheimer's disease.
- \$80,000 was awarded to two community coalitions, which include local public housing authorities, to implement a pilot program, Hope in Housing. These pilot programs will provide additional home care services, supervision, care coordination and meals to approximately 150 residents of subsidized housing in Brattleboro and Rutland.
- \$120,00 was appropriated by the 1997 Legislature, through the Department, to match a \$306,912 federal Americorps grant awarded to the Area Agencies on Aging (AAAs). The AAAs are developing a statewide network of volunteer services to assist elders to remain independent.

BUILDING THE COMMUNITY-BASED LONG-TERM CARE SYSTEM CONTINUED

- \$125,186 in Independence Fund grants was awarded by the Agency of Human Services, through the Department of Aging and Disabilities, since FY96. Matched at the local level, these funds generate a total of \$321,815 for programs designed to allow older Vermonters and younger persons with disabilities to remain in their communities and avoid nursing home placement.
- \$160,000 was granted to 9 local agencies (either AAAs or a Home Health Agency) to manage the Medicaid Waiver Program at the local level. This responsibility includes managing access to the Waiver, prioritizing admissions, and most importantly, conducting outreach to identify and provide Waiver services to persons who otherwise would need nursing home placement.

COMMUNITY-BASED COALITIONS ARE KEY PLAYERS IN A NEW ERA OF PUBLIC- PRIVATE PARTNERSHIPS

- Local community-based coalitions are assuming leadership roles in the planning and management of their long-term care systems and are intricately linked to the successful reform of this burgeoning system.
- In a creative partnership with state officials, local coalitions have received Act 160 funding for various activities targeted at reducing unnecessary nursing home utilization and creating a range of viable long term care options.
- As the coalitions become more organized and sophisticated, they will take on further responsibility for deciding how long-term care dollars are spent in their communities. As a result, local coalitions will be beholden to their own communities in creating options that reflect consumer needs and preferences.

LOOKING TOWARDS THE FUTURE: INVESTING IN OUR COMMUNITIES

- Act 160 officially sunsets in the year 2001, but our commitment to expanding choice and community-based options for older Vermonters and younger adults with physical disabilities extends well beyond the legislation which ignited this paradigm shift.
- It is our belief that a consumer-driven system based on a wide array of quality services, informed consumer choice, accountability and flexibility, will be best served by the Department working in partnership with local community-based coalitions and managed, where possible, at the local level.
- It is our vision that this partnership will help create a long-term care system which fulfills consumers' desires to live with dignity and independence in the environments they prefer.