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Vermont's Choices for Care Medicaid Long-Term Services Waiver: Progress and Challenges As the Program Concluded its Third Year

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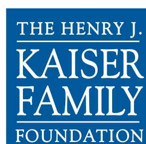
November 2008



kaiser commission medicaid and the uninsured

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Executive Director

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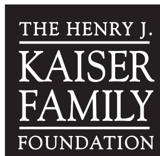


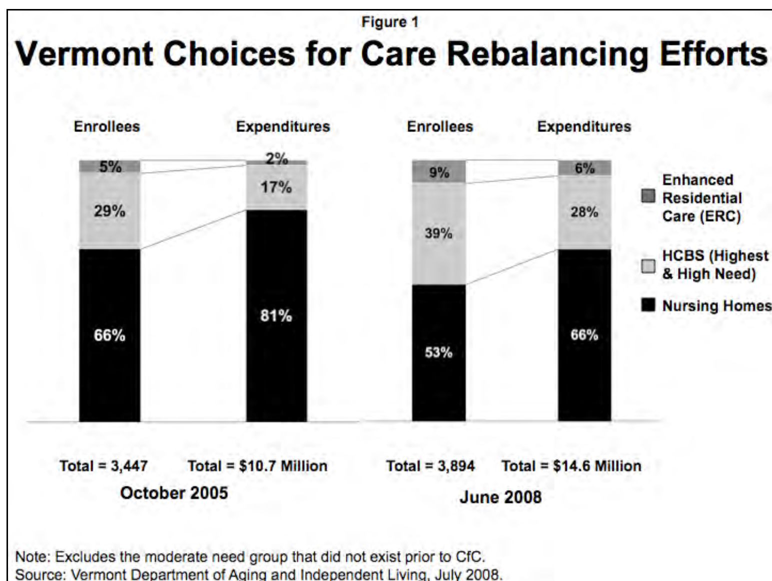
Executive Summary

In October 2005, Vermont implemented a Section 1115 Medicaid waiver program that made fundamental changes to how it provides long-term services and supports to low-income seniors and people with disabilities. Called Choices for Care (CfC), the waiver was designed to increase access to home and community-based services (HCBS) while reducing the use of institutional services and controlling overall costs. Most notably, Vermont was the first state to commit to a global cap (set at $1.2 billion) on federal financing for long-term services under the 5-year waiver.[1] This brief highlights the experience to date with Vermont's rebalancing efforts. It presents findings based on case study interviews and state administrative data.

Key Design Features of Choices for Care. In addition to the global cap, CfC is unique in the manner in which it assigns beneficiaries into three groups based on level of need—a "highest need" group that is entitled to both nursing home and community services; a "high need" group that previously qualified for nursing home care, but qualifies for nursing home and community services only as state resources permit; and an expansion "moderate need" group of people who do not yet meet the functional eligibility requirements for nursing home care, but receive limited services (as state resources permit).[2] The "moderate need" program was designed to test the theory that early interventions can be cost-effective for the state by helping to prevent increased disability and maintain people in community settings.

Findings. Since implementing CfC, Vermont has significantly expanded the number of people receiving community-based services, while experiencing a modest reduction in people receiving services in nursing homes. Since October 2005, nursing home enrollment has declined by ten percent from 2,286 to 2,059 adults. During the same period, enrollment in all community-based programs has increased. In the home and community-based (HCBS) waiver program, enrollment has increased fifty percent, from 998 to 1,494 individuals. In the smaller Enhanced Residential Care (ERC) program, enrollment has nearly doubled, growing from 173 to 340 individuals. Additionally, the state now provides a limited package of services to 1,100 "moderate need" individuals who were not receiving Medicaid long-term services prior to CfC. Satisfaction with CfC appears high among state officials. Many stakeholders, however, reported tighter financial management and reductions to individual plans of care since the implementation of CfC.

CfC has led to a significant rebalancing of where individuals receive services and where the state spends its resources for long-term services and supports **(Figure 1)**. In its first month of operation, only 34 percent of enrollees and 19 percent of state spending were in community settings. By June 2008, this had increased to 48 percent of enrollees and 34 percent of spending in community settings. This 14 percentage point increase in the share of enrollees receiving services in community settings and a 15 percentage point increase in the share of long-term services dollars allocated to community settings marks an unusually rapid change.



Spending growth in CfC has been modest and far below state projections when submitting the waiver. Over the last three years, spending growth has been less than half of the state's own projections. Spending growth was just 1.3 percent in state FY 2006 and grew to 5.5 percent in state FY 2007, putting the state on par with national spending growth for nursing home and home health services. Vermont is facing an economic downturn that is putting pressure on CfC and other state programs. While the state was able to eliminate waiting lists when CfC was implemented, modest waiting lists have returned.

Looking Ahead. The Choices for Care waiver is being watched by state policymakers around the country who are interested in reforming their Medicaid long-term care systems. Interest is high in monitoring the consequences of capping federal Medicaid funding and eliminating some federal standards governing the entitlement to nursing home services for many beneficiaries. One issue to consider is whether the reduced right to access nursing home care and tight management of care plans leaves needy individuals vulnerable to state economic conditions and shifting legislative priorities. As noted, waiting lists have returned for "high need" individuals, as well as "moderate need" individuals, and in August 2008 the Vermont legislature enacted a cut of $500,000 for CfC to close a $32 million budget shortfall.[3]

Due to unique circumstances in Vermont, it is not clear how appropriate key features of the Vermont waiver approach are for other states. Most notable, the funding cap for CfC is set at a relatively generous level and covers only long-term services users, not beneficiaries who access only acute care services. Therefore, enhanced efforts are needed to evaluate lessons from Vermont and to identify additional challenges not present in Vermont that may arise in other states seeking to adopt Vermont's model.

Introduction

Three years ago, in October 2005, Vermont implemented a Section 1115 Medicaid waiver program that made fundamental changes to how it provides long-term services and supports to low-income seniors and people with disabilities. Called Choices for Care (CfC), the waiver was designed to increase access to home and community-based services (HCBS) while reducing the use of institutional services and controlling overall costs. Most notably, Vermont was the first state to commit to a global cap on federal financing for long-term services under the 5-year Medicaid demonstration waiver.[4]

This brief highlights the experience to date of Vermont's rebalancing efforts. It presents findings based on information gathered through case study interviews, conducted in the summers of 2007 and 2008, and state administrative data from July 2008. A range of key stakeholders were interviewed in Vermont including senior leadership from the Vermont agency responsible for implementing the waiver, the Department of Disabilities, Aging and Independent Living (DAIL), as well as beneficiaries and beneficiary representatives, legal advocates, case managers, community-based services providers, a representative of an independent living center, and a representative of the state's nursing home association.

Development of Choice for Care (CfC)

Vermont's experiment with CfC fits into a broader context of the state being a leader in many respects on health coverage. Vermont is one of a small number of states to implement legislation intended to be the first steps toward universal coverage. In 2006, following the enactment of CfC, Governor Jim Douglas signed a 2006 health care affordability law, which provides the foundation for Vermont's Health Care Reform Plan. This plan included the establishment of Catamount Health, a program to provide insurance to certain uninsured Vermonters with no access to employer-sponsored insurance, as well as premium assistance for people with income below 300% of poverty, and an employer requirement to offer health insurance (with a fee for non-compliance and a small business exception).[5] This initiative built on previous initiatives to expand access to health insurance.

During the same time period that Vermont was establishing CfC, it also received a Medicaid waiver in the fall of 2005 called the Vermont Global Commitment Waiver, that imposed a global cap on the federal share of the state's acute care portion of its Medicaid program. As with CfC, the global cap is in marked contrast to the regular Medicaid financing structure, which provides states with guaranteed federal Medicaid matching funds for all Medicaid services provided to Medicaid beneficiaries. This waiver established the state as a managed care organization which allows it to pay itself a premium for each beneficiary that it serves. It permits the state to use federal Medicaid funds for state fiscal relief and non-Medicaid health programs. Further, the waiver gave Vermont new flexibility to cut back on coverage. Governor Douglas cited state fiscal problems and the desire for more flexibility to change the Medicaid program without federal review, as the purpose of the waiver.[6]

Key Design Features of Choices for Care

CfC is a unique waiver in many respects. It is the first waiver that attempts to equalize access to institutional and community-based services, but it does this by reducing access to nursing home services for some individuals. Further, it is unique in the manner in which it assigns beneficiaries into three groups based on level of need—and in expanding access to long-term services for people who do not yet meet the functional eligibility requirements for nursing home care, albeit not as an entitlement, but only as long as state funding allows. As discussed previously, CfC is part of a larger state effort to achieve health financing reform. The Governor and key legislators were very concerned over the long-term trends related to financing Medicaid long-term services, and as with the Global Commitment Waiver, reform was driven by the desire for greater financial flexibility—and the risks of a global cap were deemed acceptable because of the generous nature of the cap. Below are some key design features of CfC:

Eligibility. Coverage under CfC is available to individuals with income up to 300% of SSI ($1,911 per month for a single individual in 2008), 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. In future years, if funding is available, this limit will be phased up to $10,000.

The waiver includes all beneficiaries in nursing homes, all people in the previous aged and disabled home and community-based waivers, all people in the previous Enhanced Residential Care (ERC) waiver and new PACE (Program of All-Inclusive Care for the Elderly) participants. CfC excludes children, persons in Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), persons in mental illness and traumatic brain injury (TBI) waivers, and other limited exclusions.

CfC establishes three levels of need for long-term services and supports. Individuals are assigned to one of three groups using an independent living assessment that has been used 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 are 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: This group consists of individuals whose functional limitations make them eligible for nursing home care, but under CfC, do not meet the level of care criteria for the "highest need" group. In some cases, the divide between a "highest need" and "high need" individual can appear ambiguous, but is intended to differentiate severity of need. For example, individuals with a severe impairment with decision-making skills and specific behavioral symptoms (such as aggressive behavior) qualify as "highest need" individuals, whereas

individuals with impaired judgment that requires constant or frequent direction in performing certain activities of daily living qualify as "high need".[7] "High need" individuals have extensive needs for personal care and rehabilitation services. Individuals in this group have access to long-term services within the waiver, as funds remain available.

Many of the persons in the "high need" group previously received services through the HCBS waiver program. These individuals were 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 CfC started, however, the services they receive are subject to availability of resources.

"Moderate Need" Group: This group is an expansion population not previously eligible for Medicaid long-term services. It consists of persons who do not qualify, either clinically or financially, for a nursing home level of care. Individuals in this group are served with limited service options, as funds are available, with a specific allotment of funds set aside to provide services to this group.

Benefits. CfC covers only long-term services and tiers services according to need, subject to available funding. Acute care services, such as physician and hospital services, as well as home health services (including physical, occupational and speech therapy) are not delivered under CfC, but are separately covered for CfC participants by Medicaid, but costs for these services of CfC participants are included within the CfC global financing cap. 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 for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), 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 in residential care homes.

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

Financing. CfC operates under a five-year global budget cap set at $1.236 billion. This means that, unlike the open-ended matching financing that exists for other Medicaid programs, where the federal government matches state Medicaid spending on an open-ended basis, the state is at-risk for all Medicaid costs under the program above a certain negotiated level. This limit on federal spending was also observed in Vermont's Global Commitment Waiver, that was

approved several months after the approval of CfC, but which was implemented over roughly the same time frame.

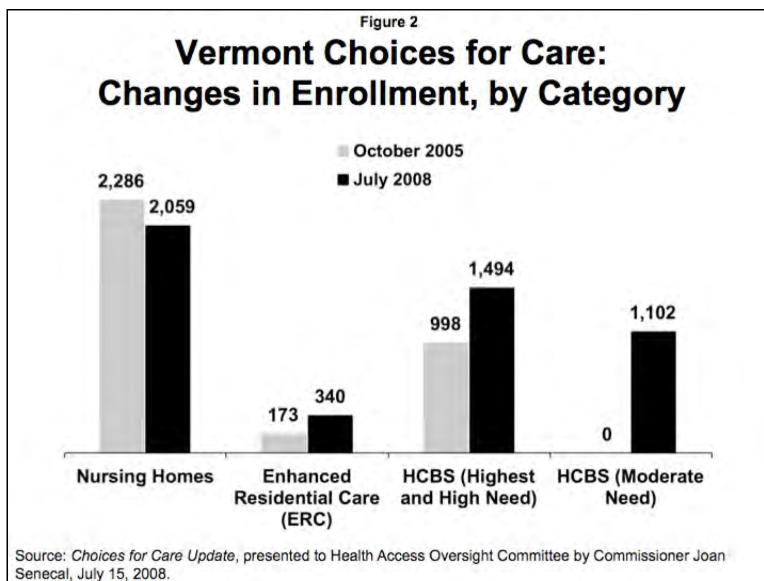
Vermont's funding for all long-term services, including nursing facility and HCBS services are subject to the cap. This amount is based on projections regarding the demand for, and cost of, long-term services by low-income elderly and individuals with physical disabilities in Vermont, based on past service use and spending and projections of state spending in the absence of the waiver. In applying for the waiver, the state indicated that they hoped to save $61 million on existing populations through greater use of community services, and stated that, subject to appropriations, it would use 90% of the savings for spending on the "high" and "moderate need" groups.[8]

Early Program Experience

The initial interviews for this case study were conducted nearly two years after CfC was implemented with selected follow-up interviews conducted roughly a year later. This remains a short time window to assess long-term program impacts. Data are accumulating, however, to assess how well the program is functioning thus far. The following sections discuss implementation and early experiences surrounding CfC enrollment, spending, benefits and delivery system.

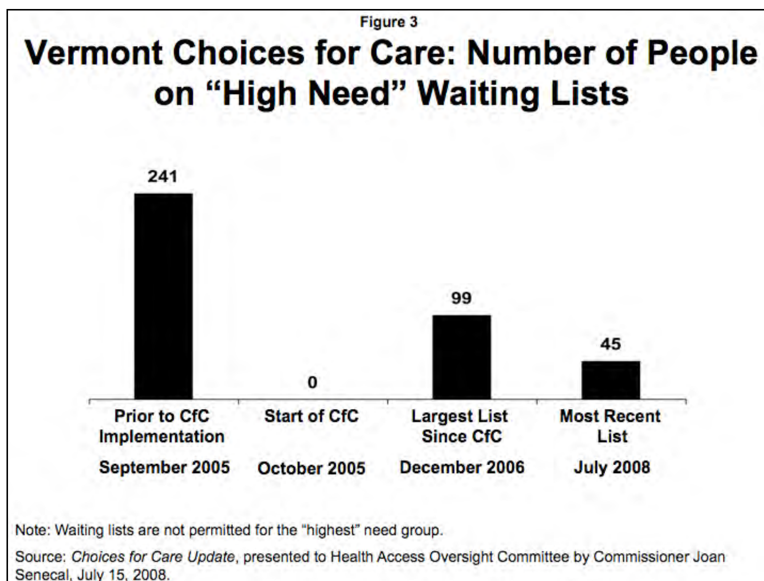
Enrollment

Vermont has significantly expanded the number of people receiving community-based services, while experiencing a more modest reduction in the number of people receiving services in nursing homes (Figure 2). As of July 2008, 2,059 adults were being served by Medicaid in nursing homes and 2,936 individuals were being served in community settings. Since October 2005, nursing home enrollment has declined by ten percent from 2,286 to 2,059 adults. Meanwhile, enrollment in all community-based programs has increased. In the home and community-based (HCBS) program enrollment has increased fifty percent, from 998 to 1,494. In the smaller Enhanced Residential Care (ERC) program enrollment has nearly doubled, growing from 173 to 340 individuals. Additionally, the program now provides a more limited package of services to moderate need individuals who were not receiving Medicaid long-term services prior to CfC. The moderate need program is currently serving 1,102 individuals.



While CfC likely accelerated the rate of change, Vermont was moving forward with rebalancing prior to CfC. Nursing home caseloads declined by 9.8 percent from 1999-2003 while HCBS caseloads increased 63.2 percent and enhanced residential care caseloads increased by 91.9 percent during the same period.[9]

While the state had eliminated waiting lists for home and community-based services for several months, modest waiting lists have recently returned (Figure 3). Just prior to implementation of the waiver in September 2005, there were 241 people who met the functional criteria for nursing home care and who were on a waiting list for HCBS waiver services. These are individuals who have extensive needs for personal care and rehabilitation services. At CfC implementation, all people waiting for services were added to the program. Over time, a new waiting list developed for "high need" individuals, rising to a CfC high of 99 people in December 2006. For several months in 2007, there was no waiting list. Recently, however, a waiting list has returned due to recurring state financial pressures. As of July 2008, there were 45 people on the "high need" waiting list.[10]



The expansion of services to "moderate need" individuals is one of the most noteworthy aspects of the program. The moderate need program is currently providing case management, adult day, and homemaker services to 1,100 people who were previously ineligible for community services prior to CfC.[11] An additional 184 people were on the moderate need waiting list as of March 2008 for homemaker services and 23 people were on the moderate need waiting list for adult day services.[12] The state is testing the hypothesis that by investing in limited services earlier—before individuals require a nursing facility level of care—they can prevent the progression of disability. If this expansion works as intended, it holds the potential to both save the state resources and help Vermonters to retain their independence. It should be noted that Vermont provided some of these services prior to CfC, but the inclusion of the moderate needs group in the waiver enabled the state to expand access to these services and made the funding more secure by making them eligible for federal matching funds.

As described by many stakeholders we interviewed, the moderate need program has not been adequately developed. This reflects their view that, while a significant number of people are receiving services as part of this group, the state has not focused sufficient attention on assessing the needs of this group, and tailoring the program to meet their needs—in order to actually succeed at preventing further disability by providing early access to minimal, targeted services. State officials continue to believe that the moderate need program is an important component of CfC, but acknowledged that more attention could be focused on developing and evaluating the program.

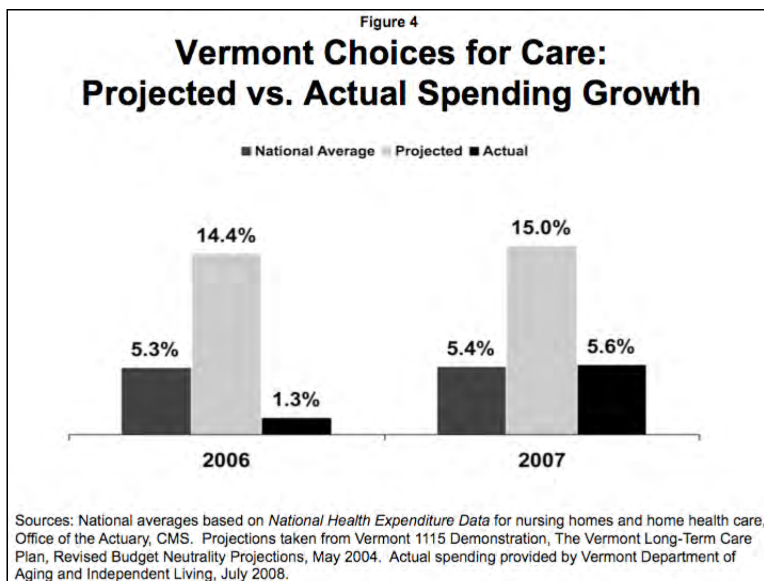
The bifurcation of the state's Medicaid program poses challenges to certain operational aspects of CfC that can delay enrollment and access to services. During our interviews, CfC was consistently described as a program that is separate and different from Medicaid, instead of as a Medicaid program for persons who require long-term services. This stems from the manner in which Vermont's Medicaid program is structured. The Agency of Human Services (AHS) is the single-state agency that operates the Medicaid program. AHS has delegated to the Department of Disabilities, Aging and Independent Living (DAIL) responsibility for delivering long-term services (also called long-term care). If an individual needs long-term services and

seeks to apply for Medicaid coverage to enroll in CfC, the Department for Children and Families (DCF) is responsible for determining financial eligibility. DAIL is responsible for assessing functional eligibility for CfC and providing long-term services under the program. Under the Global Commitment program, AHS has also delegated responsibility for paying claims related to acute care services (such as physician and hospital care), except for the CfC waiver, to the Office of Vermont Health Access (OVHA), further adding to the system's complexity. In establishing eligibility and enrolling individuals in CfC, DCF and DAIL must closely coordinate their activities, as individuals meeting the functional criteria for CfC may have income up to 300% of the SSI payment level, whereas people with disabilities who do not need long-term services may still qualify for Community Medicaid, but at a much lower income level. The bifurcation of responsibility for assessing eligibility for Medicaid and CfC (which existed for HCBS waiver services prior to CfC, and is not a problem created by CfC) has created confusion as to where individuals who have problems gaining eligibility or accessing services must go to resolve problems with DCF and other problems with DAIL.

In the context of CfC, a major concern has been the amount of time it can take to establish financial eligibility. State officials acknowledged that the delays in determining financial eligibility, which can take months, are problematic. One proposal to partially address this issue that has been discussed in the state is to adopt a presumptive eligibility system for supplemental security income (SSI) beneficiaries (i.e. persons whom Social Security has already determined to have a disability and income low enough that they receive federal income support payments). Individuals with income above the SSI level would not be presumed to be financially eligible and would have to go through the regular eligibility determination process. Individuals receiving SSI, however, would be presumed to be financially eligible for Medicaid and would be enrolled immediately if they meet the functional criteria for CfC. DAIL would conduct a functional assessment for CfC services as part of the enrollment process. After the fact, DCF would confirm financial eligibility. This could be an important step in making sure that individuals in need of long-term care have timely access to necessary services and supports.

Spending

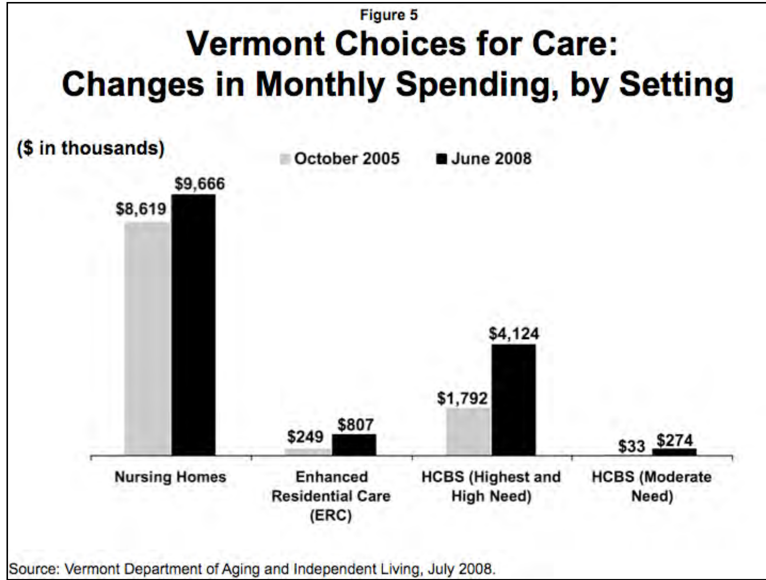
Spending growth in CfC has been modest and far below state projections (Figure 4). Spending in FY 2006 increased only 1.3 percent over FY 2005, and spending in FY 2007 increased only 5.6 percent compared to FY 2006. As a point of reference, spending growth for long-term services was below the national average in 2006 and on par with the national average in 2007. Vermont's spending under CfC has been well below its budget projections made prior to the start of the program. In 2005, 2006, and 2007, the state spent only 65 percent, 58 percent, and 53 percent of its own projected spending under the waiver. This discrepancy between projected and actual spending is due to the incentive to obtain the highest possible global financing cap, and the state's actual spending projections were likely significantly lower than was reflected in their waiver submission.



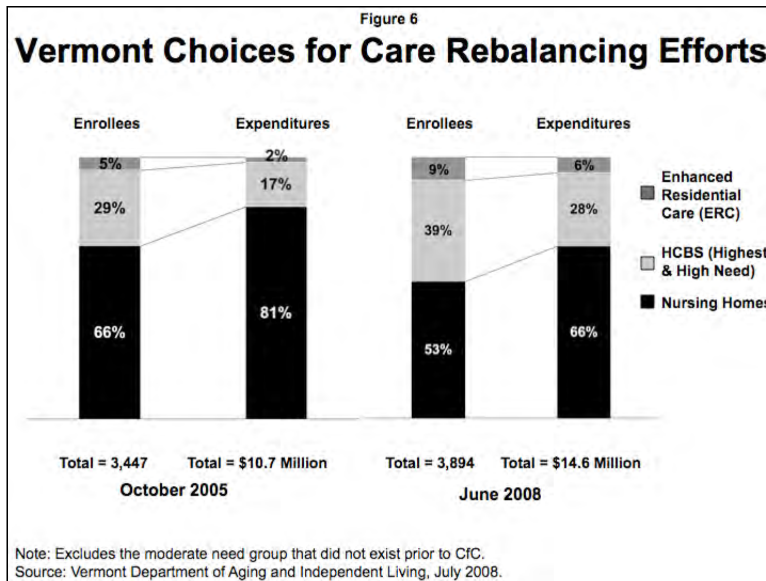
Sources: National averages based on *National Health Expenditure Data* for nursing homes and home health care, Office of the Actuary, CMS. Projections taken from Vermont 1115 Demonstration, The Vermont Long-Term Care Plan, Revised Budget Neutrality Projections, May 2004. Actual spending provided by Vermont Department of Aging and Independent Living, July 2008.

As discussed previously, CfC represents a unique waiver approach and a key element of this is the global financing cap. To assess whether a federal financing cap is a reasonable trade-off for a state, the level of the cap is a critical consideration. Vermont, as with any state, would have an incentive to ensure that the federal financing cap is as high as possible. Therefore, the spending projections provided as part of the waiver application likely reflect the state's effort to justify the highest cap possible and do not necessarily reflect the state's true projection of its actual spending.

State spending on nursing homes has increased since CfC started, but at a much slower rate than increased spending on community services (Figure 5). Since CfC first started nearly three years ago, monthly state spending on nursing home care has increased by twelve percent, an increase of more than one million dollars in monthly spending. This was a very modest increase when compared to the 224 percent increase in spending on enhanced residential care services and a 130 percent increase for the main community-based services program (for Highest and High Need groups). As of June 2008, the state is also spending $274,000 per month on the new moderate need group, an increase from the $33,000 it spent in the first month of this new program. Vermont achieved this increase by moving General Funds from existing programs into this group. On a per capita basis, Vermont is spending far less on long-term services in community settings than on nursing home care.



CfC has led to a significant rebalancing of where individuals receive services and where the state spends its resources for long-term services and supports (Figure 6). In its first month of operation (October 2005), only 34 percent of enrollees and 19 percent of state spending were in community settings. By June 2008, this had increased to 48 percent of enrollees and 34 percent of spending in community settings. This 14 percentage point increase in the share of enrollees receiving services in community settings and 15 percentage point increase in the share of long-term services dollars allocated to community settings marks an unusually rapid change, although recent trends prior to CfC indicate that some of this progress would have been made without the waiver.



Benefits

Many stakeholders reported tighter financial management and reductions to individual plans of care since the implementation of CfC. Many beneficiaries, social workers, and legal advocates believe that a major consequence of CfC was that individual beneficiaries who were receiving community-based long-term services prior to CfC experienced significant reductions in the number of hours of services in their care plans. Some stakeholders asserted that many individuals experienced a 30 percent reduction in their services when CfC was implemented. In at least two circumstances, Medicaid beneficiaries have challenged reductions in the number of hours of services in their care plans all the way to the Supreme Court of Vermont. In one case, the Court sided with the state because the petitioner did not refute the contention that their previous level of services exceeded their actual needs.[13] In a more recent case, however, an individual who was receiving 102 hours of services every two weeks prior to CfC and had these services reduced to 75 hours under CfC had her prior level of services reinstated by the Court.[14]

This issue has at least two components. One, it is believed that a part of CfC is much more focus on managing access to services. The second component relates to a structural change in how care plans are developed under the waiver. Previously, Area Agencies on Aging (AAAs, which are non-profit agencies operating under contract with the state) did an initial assessment (generally using social workers to perform the assessment) to develop the care plan, and state staff conducted a paper review of this assessment. CfC shifted this responsibility to a network of 13 Long-Term Care Clinical Coordinators (LTCCCs) who are registered nurses and who work directly for the state. The state believes that this is a positive change that has resulted in greater consistency across the state in the level of care that individuals receive. Beneficiaries, beneficiary advocates, and case managers all told us that they believe this shift to relying on nurses has been problematic because it moves away from a social services model of delivering long-term services and supports and leans more toward a medical model.

Delivery System

A major challenge for Vermont—and all states—is ensuring an adequate capacity to provide services in the community, including shoring up the supply of direct care workers. Efforts to rebalance the long-term services financing system require a greater supply of workers that are chronically in short supply. These are often physically demanding jobs, with limited opportunities for career advancement. Low wages and limited benefits have also traditionally been issues. Vermont's program is predicated on requiring individuals to obtain as much family support as possible. One caregiver reported to us that she is committed to caring for her ex-husband, but low wages and limited respite services makes it daunting. Obtaining significant paid or unpaid caregiving from family members varies dramatically by individual circumstances. For some individuals, there is a spouse or other family member willing and able to provide services, and in other cases, there is not.

In response to the shortage of direct care workers, state officials believe that consumer direction is a very important component of CfC. Consumer direction within CfC gives individuals the capacity to manage some portion of the Medicaid long-term services they receive, and they can be responsible for recruitment and supervision of a direct care worker. For many individuals, this is an important option because it gives them the opportunity to exercise greater control over

the services they receive. Vermont reports that over 60% of personal care hours delivered in CfC are under the consumer/surrogate directed option.

Looking Ahead

Experience to date shows that Vermont is meeting its goal of serving more people in the community and is reducing the use of institutional services. It has expanded coverage to "moderate need" individuals in order to better target those at risk for future nursing home use. However, the waiver does pose some risk to Medicaid beneficiaries, in the form of reduced benefits or reduced access to nursing facility services. In Vermont, state officials have argued that the lost guarantee of access to nursing home services for people in the "high need" group was essential for generating the political support to move forward with CfC. Since rebalancing is widely viewed as cost-effective and community services are seen as more responsive to consumer preferences, however, it is likely that the state could have achieved a significant rebalancing by implementing CfC while maintaining an entitlement to nursing home services for the "high need" group. If the state were to provide "high need" individuals with adequate community services and individuals prefer to live in the community, the nursing home entitlement should function as a rarely exercised protection with little fiscal impact for the state.

Looking ahead, it is critical for the program's long-term viability that the state match individual demand for community services with an expanded capacity to deliver community services. Shortages of direct care workers and insufficient capacity to provide community services are ongoing challenges for CfC and other state Medicaid programs.

Savings from CfC have facilitated the expansion of community services, however, the concept of a global cap alters a fundamental aspect of the Medicaid federal-state partnership—shared risk between the federal government and the states. For Vermont, the high level of spending permitted under the cap mitigates this risk. It is questionable whether other states seeking to implement a similar system would receive such generous financial terms and therefore, whether Vermont's program is applicable as a national model.

The level of the Global Commitment Waiver's financing cap has generated controversy both in Vermont and nationally, over the level of the cap. Some observers have raised similar questions over the global cap in the CfC waiver. Federal auditors have not examined the level of the CfC cap, but their review of the Global Commitment Waiver lends credence to some of the questions of whether the CfC cap is artificially high. The Government Accountability Office has examined the Global Commitment Waiver in 2007 and again in 2008.[15] In 2008, the GAO examined whether the Secretary of Health and Human Services ensured that a Florida waiver and Vermont's Global Commitment Waiver would be budget neutral to the federal government. GAO stated,

> "HHS did not adequately ensure that Florida's and Vermont's Medicaid demonstrations will be budget neutral to the federal government before approving them. The spending limits that HHS approved for the two demonstrations were higher than the limits that would have been granted if HHS had held the states to limits based on HHS's benchmark

> growth rates. … For Vermont, HHS approved a 5-year spending limit for the demonstration of $4.7 billion, an amount $246 million higher than supported."[16]

Therefore, for other states considering adopting Vermont's approach, the risks associated with accepting a global cap on federal financing may be higher than in Vermont, as Congressional scrutiny may prevent approval of an artificially high cap.

Another issue to consider is the fact that savings, as a result of CfC reform, are not necessarily directed to new investments in the program. As with schools, roads, and other core state functions, health care is continually in a competition for state resources. In Vermont, this has meant that even if CfC results in savings for the state, it does not guarantee that new resources will automatically be available to make new investments in rebalancing long-term services. There is concern that the next decade will be economically difficult for the state, intensifying competition for state resources. Indeed, in August 2008, the Vermont legislature enacted a $500,000 cut to CfC, as part of an effort to close a $32 million budget gap. This cut will result in a reduction of one hour of services per week for some individuals in highest and high need groups, but it does not impact people in nursing homes or receiving ERC services.[17]

The Choices for Care waiver is being watched by policymakers around the country who are interested in reforming their Medicaid long-term care systems. Interest is high in monitoring the consequences of capping federal Medicaid funding and eliminating some federal standards governing the entitlement to nursing home services for many beneficiaries. Due to unique circumstances in Vermont, however, it is not clear how appropriate key features of the Vermont waiver approach are for other states. Most notable, the funding cap for CfC is set at a relatively generous level and covers only long-term services users. Therefore, enhanced efforts are needed to evaluate lessons from Vermont and identify the additional challenges not present in Vermont that may arise in other states seeking to adopt Vermont's model.

[1] Federal officials have approved a global cap on all services for seniors and people with disabilities through the Pharmacy Plus initiative. See *The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps*, Kaiser Commission on Medicaid and the Uninsured, May 2003, available at http://www.kff.org/medicaid/4111-index.cfm.

[2] Under the waiver, only individuals in the "highest need" group are guaranteed access to long-term services. The "high need" group only receives services as state resources permit. The state maintains that the "high need" group is still considered an entitlement group, however the waiver is currently operating a waiting list which may pose some risk to Medicaid beneficiaries in the form of reduced benefits or reduced access to services.

[3] Nancy Remsen, "Cuts hurt, but don't yet reverse policies," *Burlington Free Press*, August 31, 2008, available at http://www.burlingtonfreepress.com/apps/pbcs.dll/article?AID=/20080831/NEWS02/808310310/1009/NEWS01.

[4] Federal officials have approved a global cap on all services for seniors and people with disabilities through the Pharmacy Plus initiative. See *The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps*, Kaiser Commission on Medicaid and the Uninsured, May 2003, available at http://www.kff.org/medicaid/4111-index.cfm.

[5] *States Moving Toward Comprehensive Health Reform*, Kaiser Commission on Medicaid and the Uninsured, July 2008.

[6] Guyer, J., *Vermont's Global Commitment Waiver: Implications For The Medicaid Program*, Kaiser Commission on Medicaid and the Uninsured, April 2006.

[7] See Attachment D – Eligibility Criteria, Assessment Procedures & Tools and Level of Care Determination (page 70) of the *Choices for Care Operational Protocol, updated November 2005, available at* http://ddas.vermont.gov/ddas-publications/publications-cfc/publications-cfc-documents/cfc-1115-oprational-protocol.

[8] The Vermont Long-Term Care Plan: A Demonstration Waiver Proposal to the Centers for Medicare and Medicaid Services, October 1, 2003. See page 47.

[9] Vermont 1115 Demonstration, The Vermont Long-Term Care Plan: Revised Budget Neutrality Projections, May 7, 2004.

[10] *Choices for Care Update*, presented to Health Access Oversight Committee by Commissioner Joan Senecal, July 15, 2008.

[11] *Choices for Care Update*, presented to Health Access Oversight Committee by Commissioner Joan Senecal, July 15, 2008.

[12] *Choices for Care Quarterly Data Report*, April 2008, Vermont Division of Disability and Aging Services.

[13] Husrefovich v. Department of Aging and Independent Living, 2006 Vt. 17.

[14] In re Marcella Ryan, 2008 Vt. 93.

[15] GAO, B-309734, July 24, 2007 letter to HHS Secretary Michael O. Leavitt, "Medicaid Demonstration Projects in Florida and Vermont Approved Under Section 1115 of the Social Security Act," available at http://www.gao.gov/decisions/other/309734.pdf.

[16] GAO-08-87, "Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns," January 2008, available at http://www.gao.gov/new.items/d0887.pdf.

[17] Nancy Remsen, "Cuts hurt, but don't yet reverse policies," *Burlington Free Press*, August 31, 2008, available at http://www.burlingtonfreepress.com/apps/pbcs.dll/article?AID=/20080831/NEWS02/808310310/1009/NEWS01.

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