TESTIMONY TO SENATE FINANCE COMMITTEE

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I am here today to tell you about a better way to provide long term care services in this country. For far too long we have relied on expensive nursing home care, care that elders and people with disabilities don't even want. As the population ages, we will not be able to afford the current institutional model.

Fortunately, there is a better way. It is not a theory. It is succeeding today in Vermont, and be duplicated in any state. It can save the Medicaid program billions of dollars nationwide that can be re-directed to meet the growing need long term care, especially as the population ages.

In Vermont we have developed a long term care model that provides more people with the kind of services they want, services that allow them to remain in their own homes and communities, surrounded by family and friends. Even better, this model is cheaper than nursing home care, and allows us to care for more people than we ever could with the institutional model.

How often these days can we find a public policy that gives people what they prefer and saves money? This is one of those rare opportunities: a win for people, a win for states, a win for the federal government.

Let's examine the current system for a minute. Under current Medicaid law, nursing home care is an entitlement. That is, if you are eligible and want to go to a nursing home, the state, and federal government, must pay. On the other hand, the service that people prefer, staying at home or in a less institutional setting, is not an entitlement. Instead, you have to wait in line, even though these services, on average, are cheaper than nursing home care.

It doesn't make any sense. The more expensive service that people don't want is an entitlement, but the cheaper, more desirable service is capped and you have to wait in line for it.

Some will argue that home based care is not cheaper. However, in Vermont we conducted a comprehensive study in 2002 to compare nursing home costs to home based care. We collected all the Medicaid costs for individuals in nursing homes and people on our Waiver program. These cost included nursing home services and home health costs, but also hospital care, physician care, prescription drugs, therapies, transportation and all other services covered by Medicaid. For people living at home we also collected other state and federal benefits such as food stamps, fuel assistance, etc. When all the expenses

were collected and compared, the average cost for keeping an elder at home on the Waiver was 2/3 the cost of average nursing home care. For adults with physical disabilities, the average cost was about the same.

So, to us, if for no other reason than economics, it only made sense to expand home based care and reduce our reliance on nursing homes.

Of course, it is also the right thing to do for the elders and adults with disabilities who need care.

We had been able to make significant progress over the years in reducing nursing home use. However, the nursing home entitlement posed a significant barrier. We continued to have a nursing home entitlement but a cap on our home based waiver. Why? Because policy makers, budget staff and legislators were worried that if we expanded home based care too much, we would have a "woodwork" effect, and have an uncontrollable home based care system. So, instead people would end up in more expensive nursing home care because they could not stand to wait on the home based care waiting list any longer.

My staff and I were frustrated by this one-sided entitlement, and did not believe that expanding home care would be a problem, but no state is going to create another open ended entitlement in these times.

So we applied to CMS for an 1115 Waiver that would let us re-design our long term care system and create more flexibility. In its simplest terms, our Waiver provides an equal entitlement to either nursing home care or home based care, but in a way that lets us manage to the available funding. We want to thank and acknowledge the people at CMS who grasped what we were trying to do and gave us the chance to radically reform the system.

Our theory was that, given a choice, more people would choose home based care. Since that care, on average, is cheaper, we could serve more people for the same amount of money. We would use nursing home care less, and those savings would be transferred to cover more home based care for more people.

However, we also needed some mechanism for controlling costs if our projections were wrong and our home based costs were far more than anticipated. So we requested and CMS approved a process that permitted us to put the lightest care people on a waiting list if necessary. Keep in mind that we always had, and every state has, a waiting list. The problem is that the waiting list is only for home based care; there is no waiting list for nursing home care. That was neither fair nor logical. Under our system, the highest needs persons get served first, and can choose either option. Lighter care people may have to wait, for either option.

This is a key element to reforming the system. Armed with this new equal access to either nursing home care or home based care, yet with the ability to control over all costs, we implemented the program in October 2005.

So what happened? So far, the program is working just as it was designed. We are serving twice as many people at home as we could have under the old system. Nursing home use is down, and we are operating within our budget. We have had a small waiting list on and off, but today there is no waiting list.

Since the program started we have added 467 new people to either home based services or alternative residential settings such as Assisted Living. At the same time, the number of people in nursing homes has decreased from 2286 to 2038.

The program has worked almost exactly as planned. There has not been any uncontrollable "wood work effect". Even if there was, the ability to serve more people for the same amount of money means the state can absorb a degree of "wood work effect".

There other elements of our program that have been important for our success and that we would recommend to any state.

The first is to have a portfolio of services. We offer not only personal care and case management, but respite, residential care, adult day, adaptive equipment and home modification. We also offer a very flexible "cash and counseling" option. It is important to have person centered, flexible options because every person's needs are different.

Another key option is consumer direction. Consumers, whether elders or adults with physical disabilities, know best what will meet their needs. For years we have offered a consumer directed option that permits consumers to hire their own care givers instead of relying on agency services. This is very effective and positive for several reasons. First it gives consumers control of their services, and results in much higher consumer satisfaction. Second, by letting consumers hire family members and friends, it supports the natural supports that people have. Third, it is a far more cost effective option than agency services. In Vermont, the consumer directed option costs the state about $13 per hour, while agency services cost $26 per hour. Lastly, this option brings thousands of family members and friends into the care giving system that would never work for an agency, and thus helps address the shortage of caregivers.

One constant concern raised is about what happens to nursing homes. Some suggest we will need all of our nursing homes as the boomers age. Not so. We need new and different options, and the kind of alternative settings that the boomers will demand. Not to mention the boomers will not need nursing home level of care for another 15 to 20 years at least, by which time most of our current nursing homes will be obsolete. Some argue that nursing homes need to be kept open because they are major employer. Not so. In a reformed system there will be just as many if not more jobs in the home based care system. It is possible to manage the downsizing of our nursing home system. The kind of change we are engaged in does not result in mass closings of nursing homes. The change can be managed in an orderly manner. Some nursing homes will close; they already are. Others can be helped to become smaller more efficient facilities, and change their environments and how they operate.

Any state can do what we have done. Yes, it is easier to make progress faster in a small state like Vermont, but the principles are the same. In fact, many states are adopting some of the same approaches.

However, other states cannot adopt the same model as Vermont until the Congress and federal Government give them the same opportunity to re-design their long term care systems that we have. They need the same permission to provide equal access to either home based care or nursing home care, with the ability to control expenditures. This is the key to reforming long term care and being ready for the aging of America.

CMS and Congress have taken some steps in this direction, promoting Cash and Counseling, and passing some helpful provisions in the DRA. But these are tentative steps that will only result in incremental change. A larger change is needed and needed now. Even with a fundamental change in federal law, it will take states years to completely re-design their systems to fully reinvent themselves. We need to change the law now.

Fortunately, the solution is clear. We can do this and it can work.

The State of Vermont stands ready to help Congress, CMS or any state design and develop a system that truly serves people.