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**Testimony of Governor Howard Dean, M.D. (D-VT) to the
Senate Special Committee on Aging
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Mr. Chairman and members of the Committee, my name is Howard Dean and I am Governor of the state of Vermont. I appreciate the opportunity to appear before you today to discuss – from a state perspective – an emerging health care issue with major ramifications for both the Medicare and Medicaid programs.

We are all acutely aware that our society is aging. In 25 years, the population over age 65 will represent 18.5 percent of all Americans, an increase from 12.6 percent today. People over 80, those most in need of long-term care, will grow by nearly one third. In the face of these trends, our current approach to long-term care simply will not meet the need. The cost for continuing business as usual will be enormous and unsustainable. We must instead develop a new fundamental structure for long-term care, one that emphasizes independence, dignity and choice for the people we serve, and which does so through creation of flexible programs and funding that are financially sustainable by the states.

Before expanding on these themes, I want to commend you for including representatives from the states in your planning activities. I am certain that we all share the same principles with respect to our nation's long-term care system – that it be efficiently operated, but also that it offer opportunities for self-determination among patients and their families and that it enhance the dignity and quality of life of those it serves. I also firmly believe that we can advance these principles only if the states and federal government – as the two major payers of long-term care—work together in partnership to reform the existing system.

With these common principles in mind, I would like to begin today by talking briefly about the long-term care environment in Vermont and what we in our state see as the necessary components of any compassionate and financially rational long-term care system. I will describe how we have tried to put these components into place over the last several years, and the obstacles we have encountered. I will then conclude by offering some specific recommendations on how states and the federal government can work together to remove the obstacles that bar the path toward improving the quality of life for our frail elderly and disabled citizens.

Long Term Care in Vermont

While Vermont is smaller and more rural than many other states, our long-term care system is similar to what exists in the rest of the country. This is no accident, since much of the structure for long-term care has been molded over the years through federal regulation and entitlements.

If you are an elderly or disabled citizen of our state today, and in need of long-term care services, sooner or later you will most likely find yourself coming into contact with the Medicaid program. Even if you qualify financially, however, one of the first difficulties you will encounter is the way in which medical eligibility tests must be administered. Because it is an entitlement, traditional Medicaid exists as an “all or nothing” proposition for potential recipients. Take the case of a 65-year old widow who lives alone on a fixed income and wants to remain in the house where she and her husband raised their family. She is generally in good health, but to be able to stay, she needs some modifications made to her house, such as the installation of a wheelchair ramp. She also needs some light assistance with housekeeping. We can offer her these kinds of services through Medicaid only by qualifying her for the whole entitlement.

And the fact is, she may not qualify for the program. Long-term care eligibility in Vermont and other states is measured in one way or another against the yardstick of nursing home care. If you need assistance with activities of daily living to such an extent as to justify admission to a nursing facility, then and only then will you qualify for Medicaid long term care.

So there is not much we can do through Medicaid for this woman until her health further declines. Let us take the case of another elderly Vermonter, who is living at home with his wife and could remain there with the right combination of intensive medical and social supports. Absent these supports, the only recourse for his wife will be to place him in a nursing facility.

Here the prospects are a bit brighter. In 1996, we enacted a law in Vermont known as “Act 160”. This law mandated the shifting of state financial resources on a defined timetable from institutional to non-institutional services. To my knowledge, it was one of the first laws of its kind in the country.

With Act 160 serving as a catalyst, we have worked to take maximum advantage of the home- and community-based services “waiver” option under Medicaid, to develop and fund an array of services designed to allow people to remain in their homes or other community settings when their only choice otherwise would have been a nursing facility.

Today in Vermont, all of the following services are available to qualifying individuals enrolled in our waiver program:

Home-health aide services – whereby a health care professional assists individuals in the home with specific health problems;

Homemaker services – including assistance with general household activities and housekeeping chores;

Personal care attendants – for assistance with basic needs such as bathing and dressing, as well as household activities like grocery shopping and paying bills. We also permit individuals to hire their own attendants;

Adult day care services – which involve transporting an elderly or disabled person to a center where they receive on-going attention and therapies before going home again for the night;

Case management services – to assist individuals to find and coordinate the various services they need;

Assistive technology and home modification – a limited benefit to help people obtain equipment or home modifications they need to remain independent and which are not covered by other sources;

Traumatic brain injury services – specialized services to assist people with traumatic brain injury remain out of an institution.

The average long-term care recipient living at home receives more than 30 hours a week of these kinds of services. We also have respite care available for spouses and other caregivers who, of course, continue to bear the brunt of the work associated with keeping a loved one at home.

And we offer full-time Residential care, for persons who are too medically fragile or disabled to remain at home, but who can safely live and age in place in a more private setting than one finds in a nursing home.

Our efforts to build a comprehensive home- and community-based service system were recognized by the federal government in 1999, when we were one of eight states selected to implement a pilot program to assist nursing home residents whose primary payer source is Medicaid to leave the nursing home and return to the community.

Federal Obstacles

As active as we have been in developing alternatives to nursing home care, the rules of the traditional Medicaid program have limited us in what we have been able to accomplish. That is because federal regulations are significantly biased toward institutional care. Nursing homes are identified as a basic service within Medicaid, but it takes a waiver for states to offer home- and community-based alternatives. The waivers themselves cap the number of people who can be offered waiver services. If others qualify, but the slots are filled, the only option we can offer is the nursing home.

We are also limited when performing our financial “test” to looking only at what Medicaid pays for and disregarding the effect of our actions on the other major public payer – Medicare. If we can intervene to improve the safety of the elderly woman’s home, thereby preventing a fall and a hospitalization, we have saved a substantial amount

of money for Medicare. But the current rules do not allow us or you to recognize the value of our actions outside of the world of Medicaid, resulting in an incomplete picture of what we have achieved.

Finally, and perhaps most importantly, Medicaid rules today permit payment for supportive housing costs in a nursing home, but not in waiver or similar programs. This drastically limits what we can do without losing federal financial support.

How have these obstacles served to direct the flow of long-term care dollars away from home- and community-based services? In 1996, when Act 160 was passed in Vermont, 88 percent of our state's Medicaid long-term care budget was spent on institutional care and 12 percent on home- and community-based alternatives.

Since then, although the number of people served through our home- and community-based waiver program has more than doubled, last year we still spent 74 percent of our long-term care dollars on institutional services, and 26 per cent on home and community based care.

We are by no means out of the mainstream when compared to other states. Nationally, in 1999, 74 percent of Medicaid long-term care expenditures were for nursing home services and only 26 percent for home- and community-based alternatives¹.

While clearly I think we can do better, I should note that I am proud of our health care providers—both institutional and otherwise—and think they do an excellent job of delivering care to our elderly and disabled. I am also proud of the active grassroots coalitions of citizens that have formed in recent years and that work at the local level to reach out to those in need and help them to remain in the community or successfully make the transition to another living arrangement when they can no longer manage on their own. But I think with the proper restructuring of Medicaid regulations, we can accomplish much more.

Components of Reform

¹ Source – Health Care Financing Administration

I cannot help but observe that there is a strong parallel in the long-term care world to what is being discussed in Congress with respect to prescription drug coverage under Medicare. First, these two benefits are among the largest expenditure items in most state Medicaid budgets, including Vermont's.

Second, I have heard a number of people make the observation that if Medicare was being designed from scratch today, it would never exclude prescriptions. That is because what made sense thirty-five years ago no longer makes sense, given the advances in medicine and changes in society that have taken place.

I think the same observation can be made about how long-term care services are funded and delivered. If a long-term care system were being designed from scratch today, I do not think we would conceive of building a system in which a bias is shown for institutional care, rather than for services designed to keep people independent in their homes or the community. Nor do I think we would segregate funding into two different programs – Medicaid and Medicare – such that the financial ramifications of a change to one program are ignored in the other.

Allow me to propose four reforms of federal policy with respect to long-term care:

- *Reform 1 – Allow greater state flexibility.* Federal policies should permit states to offer flexible benefits, for example, by permitting us to begin helping frail elderly and disabled persons before their condition is severe and when our intervention could actually do the most good. We have made a careful study of the concept of early intervention in Vermont over the past several years and have used what we have learned to design a potentially groundbreaking program, known as “Home Front”. Under this program, elderly and disabled persons who do not qualify for Medicaid, but whose quality of life and health could be enhanced through minimal interventions, would be enrolled for a limited package of services. These services would be tailored to a person's particular needs, and might include environmental modifications to their home, assistance with home chores and so forth.

Because most of these people would be on Medicare and have Part B, the program would also seek to engage their personal physicians in the design of the benefit package.

In order for us to offer a limited benefit package under existing federal regulations, the Home Front program would require a Section 1115a Medicaid waiver. This in turn means we would have to be able to demonstrate to HCFA that the program would be budget neutral to the federal government, i.e., that the federal government would spend no more on Home Front than it would have spent absent the waiver. That, unfortunately, is a difficult test to pass, when these people theoretically were costing nothing before – nothing, that is, if only Medicaid is considered.

For the Home Front program, and others like it to be implemented, one of two things must happen. Either the budget neutrality tests for persons with dual Medicare and Medicaid eligibility must be modified to look across both programs or states must be given the flexibility to offer these kinds of benefits without going through the difficulty of obtaining an 1115a waiver.

- *Reform 2 – Remove the bias toward institutional care.* In a letter to the states issued by HCFA last year in the wake of the Olmstead decision, HCFA said, “...no one should have to live in an institution or a nursing home if they can live in the community with the right support. Our goal is to integrate people with disabilities into the social mainstream, promote equality of opportunity and maximize individual choice.²” I endorse that position and would offer a shorter, “New England” re-phrasing: No one should ever need a waiver from the federal government to remain in their home.

It is important to note that a leveling of the playing field between non-institutional and institutional care will not result in massive new federal spending. The good news is that home- and community-based services, the

² State Medicaid Director letter, January 14, 2000.

services people prefer, are actually cheaper. In Vermont, the average annual Medicaid cost for nursing home care will be \$48,000, while the average cost on our home- and community-based Waiver will be less than \$20,000. The evidence from federal studies confirms that home- and community-based services are cost-effective, in part because they give states greater leverage as a payer. For example, a GAO study in 1994 concluded, “Home- and community-based services have helped control growth in overall long-term care expenditures by providing an important alternative to nursing facility care, thus helping states exercise greater control over nursing facility capacity and use³.” And this conclusion was reached without considering any potential savings garnered for Medicare.

- *Reform 3 – Emphasize self-determination and independence.* A great deal of energy has been devoted of late toward crafting a patient’s bill of rights. In the world of long-term care, there can be no more fundamental right extended to patients and their families than to have a voice in deciding where an individual is going spend the rest of his or her life. Granting this right again is dependent on the flexibility available to state Medicaid programs – making certain that states can intervene early and offer multiple options for care.
- *Reform 4 –Re-examine public financing.* As you can tell from my earlier references to Medicare, I believe the Medicare and Medicaid programs are inextricably linked when it comes to the world of long-term care. Most long-term care recipients in Vermont and other states are covered by both programs, with Medicare serving as the primary payer and Medicaid the secondary.

Since 1996, Vermont and five of our neighbors have studied Medicare-Medicaid crossover issues through a group known as the “New England States Consortium”. Working with Medicare data provided by HCFA – and

³ “Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs”, GAO-HEHS-94-167

not normally available to states – we have been able to develop a complete profile of our dually-eligible populations. From the work done by the Consortium, I can tell you that while dual eligibles represent only 17 percent of all Vermont Medicaid beneficiaries, they account for nearly half – 46 percent – of our Medicaid budget. Similarly, the Medicare program spends nearly twice as much on each dual eligible as it does on Medicare-only beneficiaries.

Clearly, assuring the fiscal solvency of both programs in the future will require that long-term care dual eligibles be addressed in a holistic fashion. If there are things that can be done within Medicaid through early intervention and other measures to reduce costs in Medicare, they should be allowed and encouraged. And the savings should be recognized on both sides of the ledger.

Federal Action

There are several things that the federal government can do to advance the reforms I have outlined. First, it can act on the proposal for comprehensive restructuring of the Medicaid program put forth by the National Governor's Association in February. This proposal, which was adopted unanimously at the NGA winter meeting, and which Governor Don Sundquist of Tennessee and I presented to Secretary Thompson in June, calls for elimination of the complex, multi-year research and demonstration waiver application process that serves to choke off innovation at the state level. The proposal also restructures the manner in which federal matching funds are distributed, to enable states to implement creative programs like Home Front.

Second, the federal government should begin to formally assess the impact of Medicaid policy changes on costs to the Medicare program, and vice versa. At the state level, this would mean allowing states to count savings generated for Medicare through Medicaid waiver programs, like Home Front, when assessing their cost effectiveness.

On the federal side, it would mean examining in advance the likely impact on states of new Medicare rules, and using that information when judging the ultimate merits

of proposed new policies. For example, when Medicare reduced payment rates for home health providers, this compelled many states, including Vermont, to raise our Medicaid rates to these same providers, to ensure adequate networks were maintained to serve the Title XIX program. Since the federal government pays for a share of Medicaid expenses, the net result was higher costs for the states and lesser savings for the federal government than would be assumed if one just looked at home health expenditures within Medicare.

Congress can determine with HCFA whether legislation would be required to permit this sort of comprehensive financial test. If so, the Title XVIII and XIX statutes should be amended to allow it. Eventually, I believe that the federal government and states are going to conclude that the only sensible approach for financing the care of dual eligibles will be to integrate the funding streams and manage patient needs and costs through a unified care management system. In the interim, however, updating the accounting rules would be a good first step.

Third and finally, is the subject of prescription drugs. While I mentioned this topic only in passing before, I want to take the opportunity to urge adoption of a prescription benefit for Medicare beneficiaries, and to ask that, if the final legislation places major responsibilities in the hands of the states for low-income seniors, that this be done in such a way as to allow for flexibility and to not penalize states that have been leaders in this area.

In Vermont, we have offered for many years a subsidized prescription drug benefit to low-income seniors who do not qualify for Medicaid. Part of the cost of this program is paid for with federal dollars under our 1115a waiver. If a Medicare benefit is adopted, this could naturally be of great help to us, particularly with regard to financing care for the long-term care population, which has among the highest of prescription costs. My concern, however, is that we not see a repeat of what occurred with the State Children's Health Insurance Program (S-CHIP).

When that program was enacted, Vermont already had some of the most generous eligibility standards in the country. Rather than being recognized for our achievements, we were restricted from using S-CHIP dollars in any meaningful way and so derived

almost no benefits. I would urge you not to take the same path in crafting a Medicare prescription benefit, but instead to incorporate enough flexibility for states that all can participate fully.

In closing, I want to return to what I stressed at the beginning of my remarks. Now is the appropriate time for the states and federal government to join in partnership to build the right long-term care system for the 21st century—one that is compassionate and fiscally responsible, and that will be equipped to serve the growing ranks of elderly and disabled in the years to come.

Thank you Mr. Chairman and members of the Committee for the opportunity to appear before you.