



Choices for Care

Data Report

January 2016

This report describes the status of Choices for Care, a core element in Vermont's publicly funded long term services and support system. This report is intended to provide information regarding Choices for Care service use, performance, and expenditures.

The primary data sources include the Harmony SAMS Choices for Care case management system, MMIS Medicaid claims, and provider reports including nursing home census data submitted to the Division of Ratesetting.

We welcome your comments, questions and suggestions.

For additional information, or to obtain copies of this report in other formats, please contact:

Bard Hill, Director
Dale Brooks, Senior Planner
Dick Lavery, Senior Program Consultant
Rio Demers, Senior Program Consultant
Policy, Planning and Analysis Unit
Department of Disabilities, Aging and Independent Living
Vermont Agency of Human Services
bard.hill@vermont.gov
<http://dail.vermont.gov>

DAIL Mission

The mission of the Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability ~ with dignity, respect and independence.

DAIL Core Principles

- **Person-Centered:** The individual will be at the core of all plans and services.
- **Respect:** Individuals, families, providers and staff are treated with respect.
- **Independence:** The individual's personal and economic independence will be promoted.
- **Choice:** Individuals will have options for services and supports.
- **Self-Determination:** Individuals will direct their own lives.
- **Living Well:** The individual's services and supports will promote health and well-being.
- **Contributing to the Community:** Individuals are able to work, volunteer, and participate in local communities.
- **Flexibility:** Individual needs will guide our actions.
- **Effective and Efficient:** Individual needs will be met in a timely and cost effective way.
- **Collaboration:** Individuals will benefit from our partnerships with families, communities, providers, and other federal, state and local organizations.

Choices for Care Core Objectives:

1. Support individual choice
2. Serve more people
3. 'Shift the balance': reduce the number and percentage of people who are served in nursing homes; increase the number and percentage of people who are served in alternative settings
4. Expand the range of service options
5. Eliminate or reduce waiting lists
6. Manage spending to available funding
7. Ensure an adequate supply of nursing home beds
8. Ensure that services are of high quality and support individual outcomes

CONTENTS

page

1. Support individual choice.....	3
2. Serve more people.....	4
3. ‘Shift the balance’	5
4. Expand the range of service options.....	10
5. Eliminate or reduce waiting lists.....	11
6. Manage spending to available funding.....	17
7. Ensure an adequate supply of nursing home beds.....	20
8. Ensure that services are of high quality and support individual outcomes.....	24
9. Other data.....	27

Note:

Vermont tracks a variety of process measures and reviews outcomes in a variety of areas in order to manage Choices for Care. These include, but are not limited to:

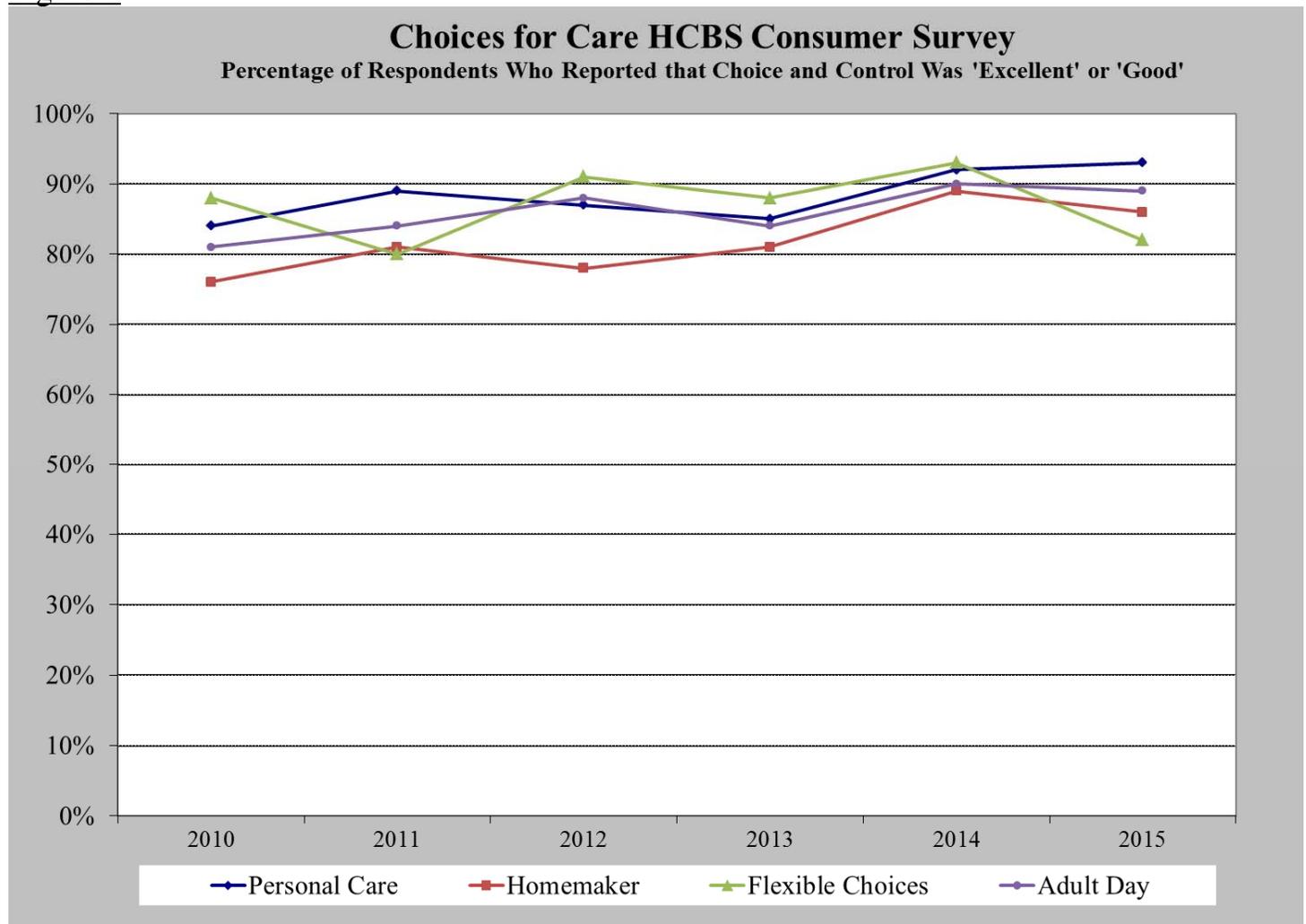
1. Managing applications, enrollment, and service authorization;
2. Tracking current and retroactive eligibility;
3. Tracking real-time trends in applications, enrollment, service authorization, service settings, individual provider performance, service utilization, and service expenditures;
4. Analyzing expenditures using both 'cash' and 'accrual' methodologies;
5. Predicting future service utilization and costs using both 'cash' and 'accrual' methodologies

Because multiple data sources are used for these purposes, sources may not be integrated or use the same methodologies for entry and extracts. For example, clinical eligibility determinations are tracked in one DAIL database while financial eligibility determinations are tracked in a separate system used by the Department for Children and Families. Due to different sources, methodologies, and purposes, information reported on CMS64 financial reports does not match information from other sources or reports.

1. Support individual choice

The primary goal of Choices for Care is to support individual choice among a range or ‘menu’ of long term care services and settings. As illustrated in Figure 1 below, a large majority of Home and Community Based Services (HCBS) participants report that they had good choice and control over home and community based services, and that these services were provided when and where they need them. Consistent with recommendations from the state auditor and the independent evaluator, DAIL has been working with nursing home and enhanced residential care home representatives to collect and share similar information from residents of these facilities. This would allow a more complete view of how people served in Choices for Care perceive their experience.

Figure 1



Data source: DAIL Consumer Survey

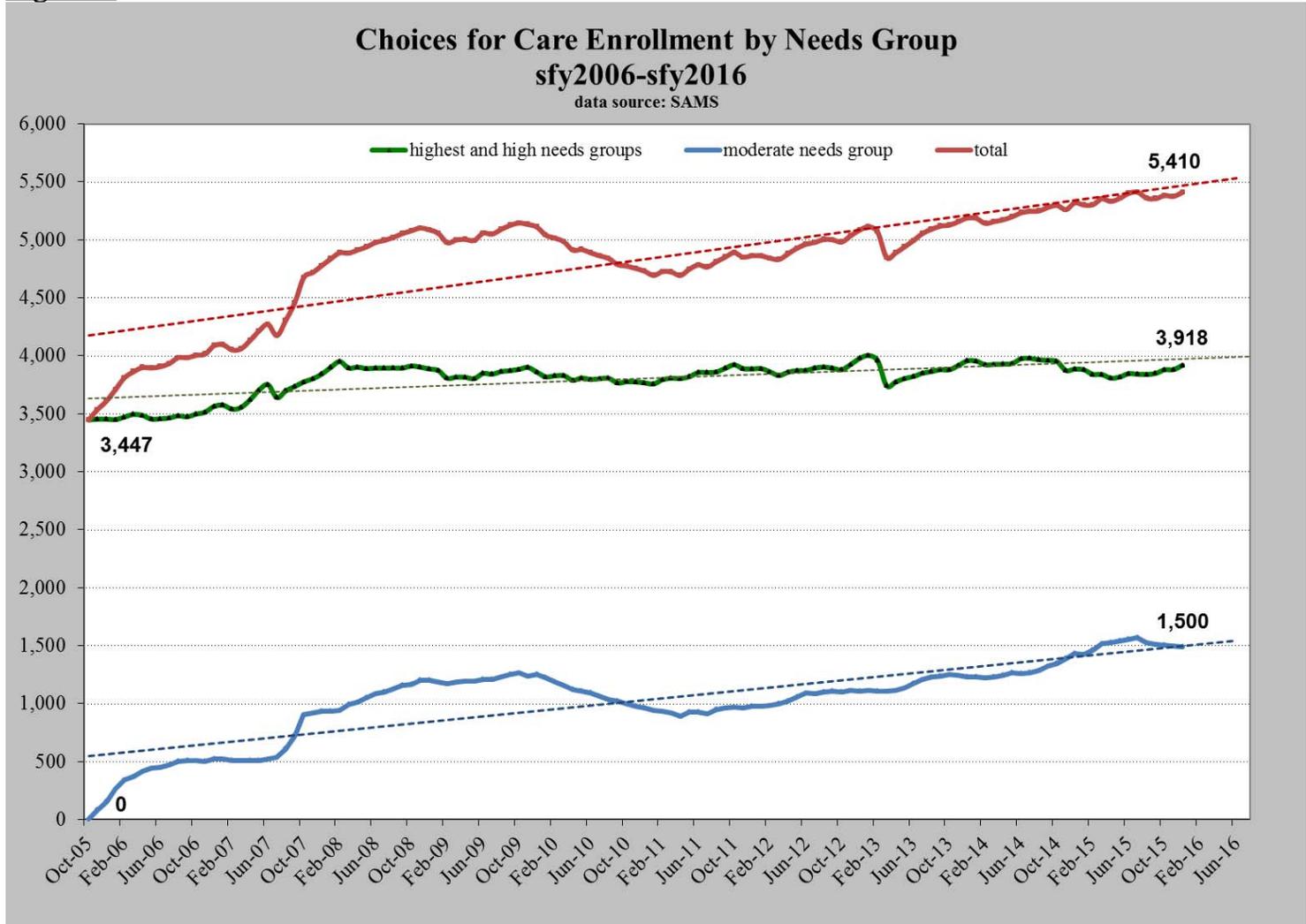
Complete survey results are available online: <http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-rpts-consumer-surveys>

2. Serve more people

One of the goals of Choices for Care is to serve more people. The number of people served by Choices for Care has increased substantially since it began in October 2005.

Figure 2 shows total CFC enrollment over time:

Figure 2

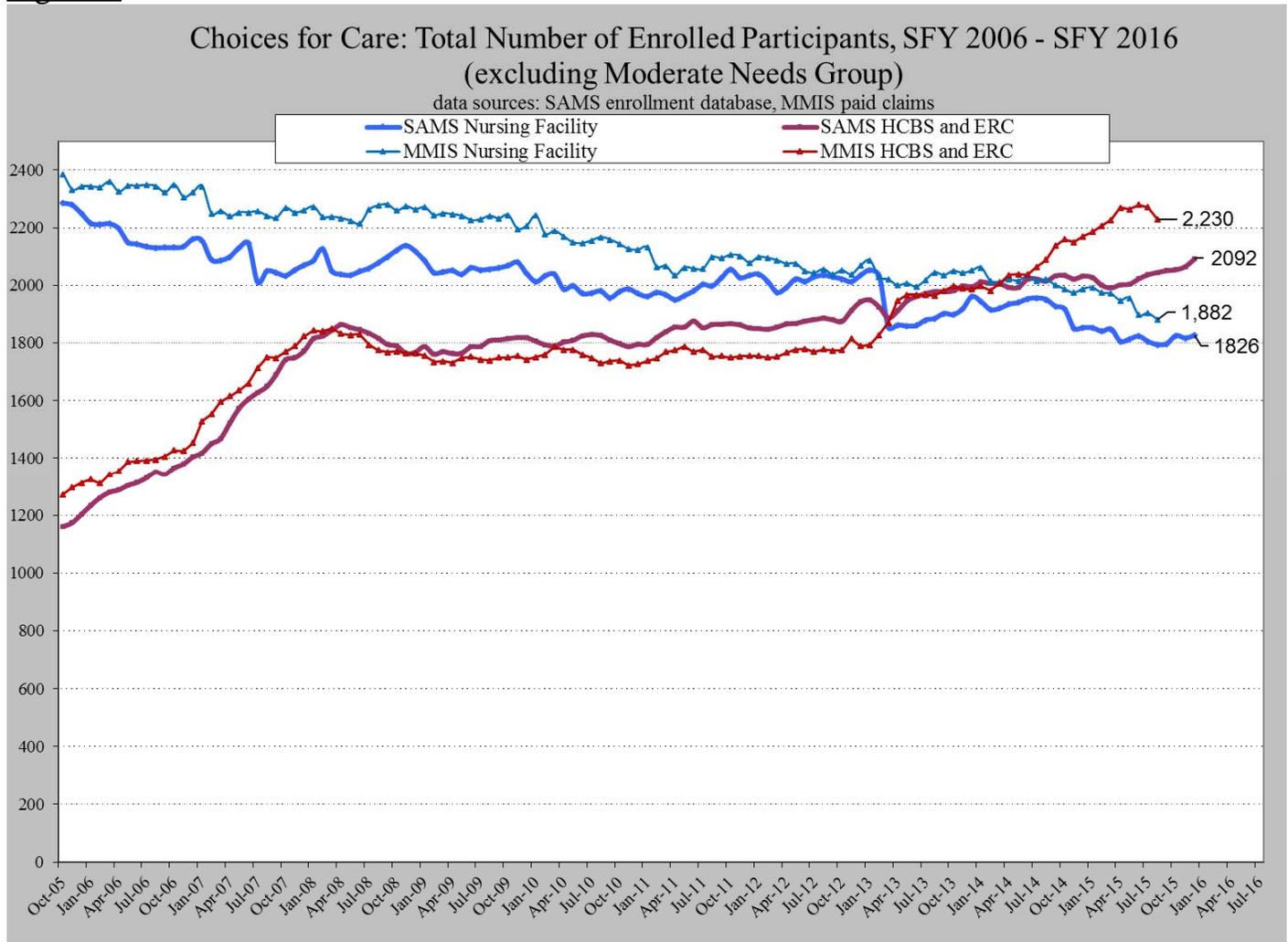


Data source: SAMS

3. 'Shift the balance'

One of the goals of Choices for Care is to 'shift the balance', serving a lower percentage of people in nursing homes and a higher percentage of people in alternative settings. As seen in Figure 3, Choices for Care has achieved progress since 2005, with enrollment in HCBS and Enhanced Residential Care (ERC) settings exceeding enrollment in nursing homes for the first time in 2013, and in paid claims in 2014. Note that delays in long term care Medicaid eligibility determinations and retroactive eligibility, coupled with turnover in participants, results in paid claims being higher than point-in-time enrollment:

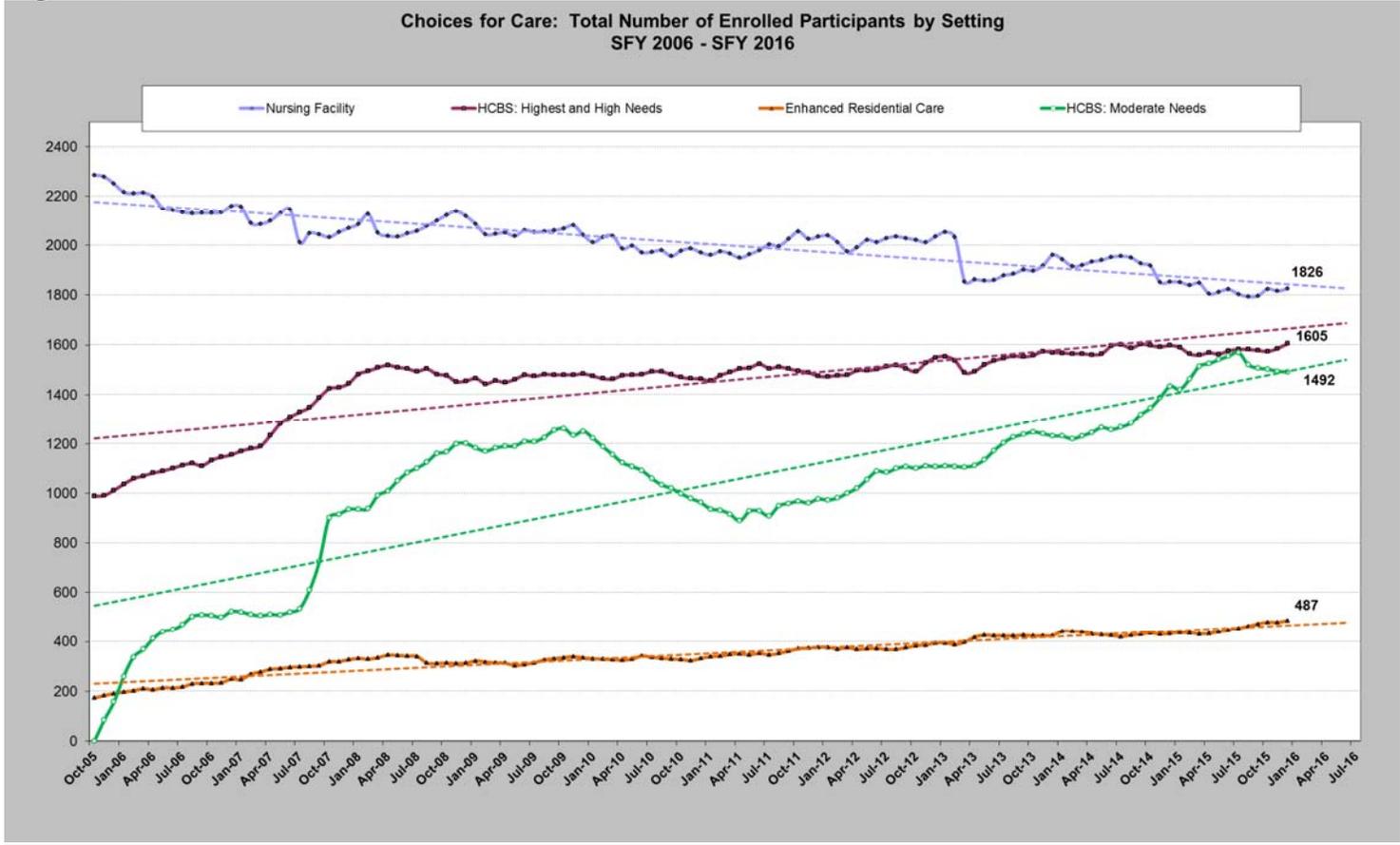
Figure 3



Data source: SAMS, MMIS

Figure 4 shows decreasing enrollment in nursing homes, and increasing enrollment in other settings:

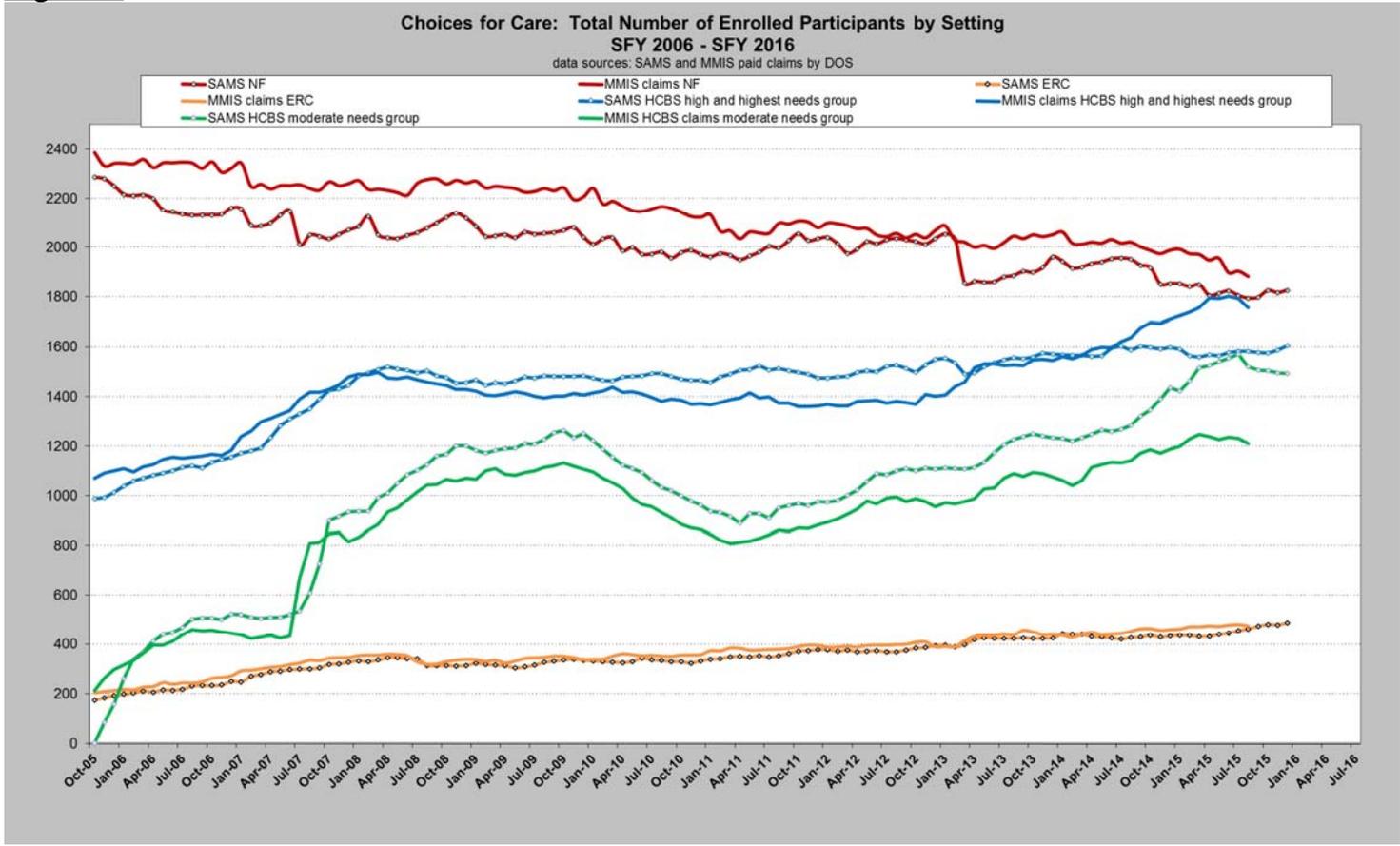
Figure 4



Data source: SAMS

Figure 5 shows both enrolment (SAMS) and actual service delivery (paid claims):

Figure 5



Data sources: SAMS, MMIS

Figure 6 shows decreasing use of nursing homes among all residents and residents supported by Medicaid:

Figure 6

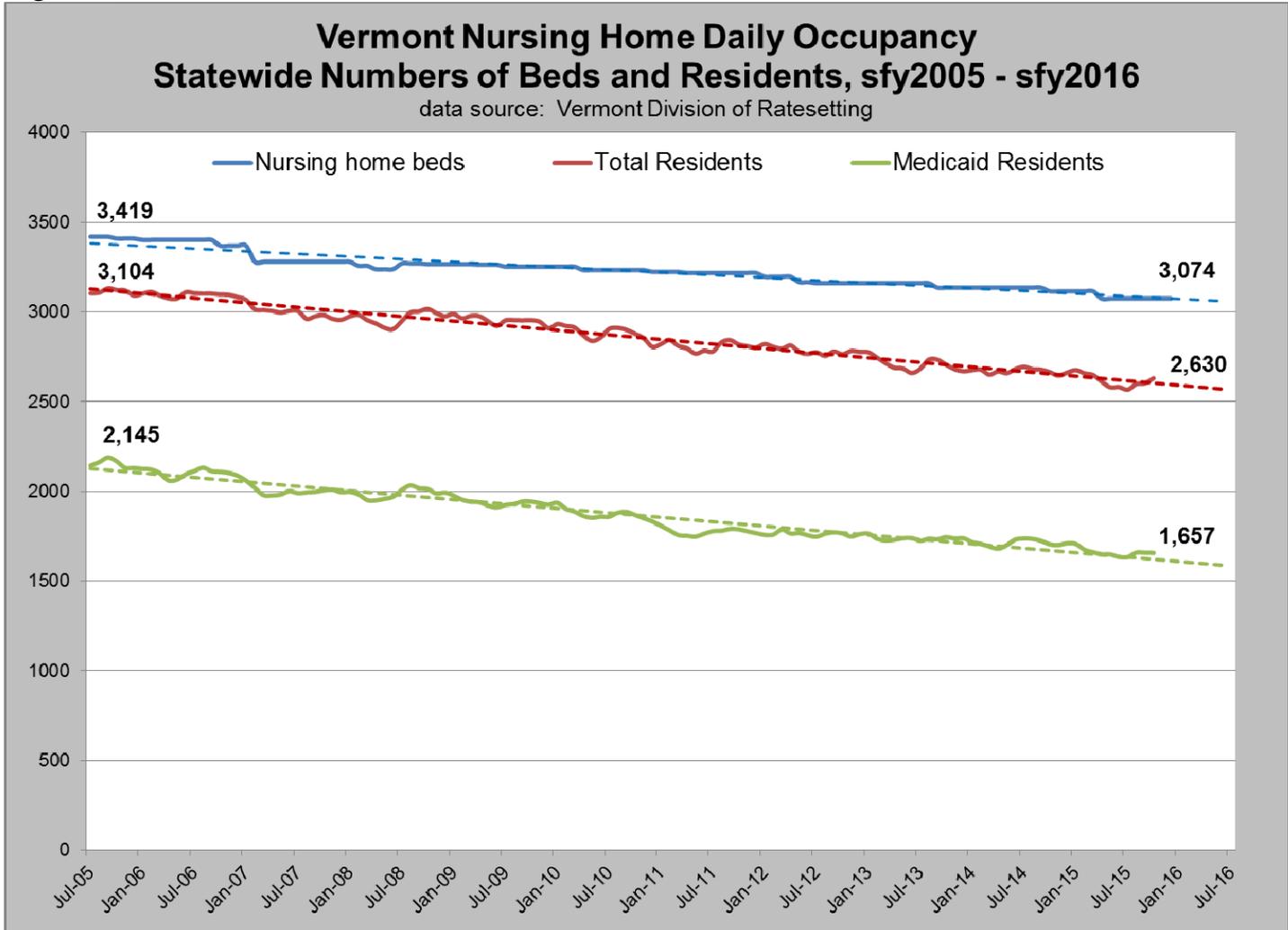
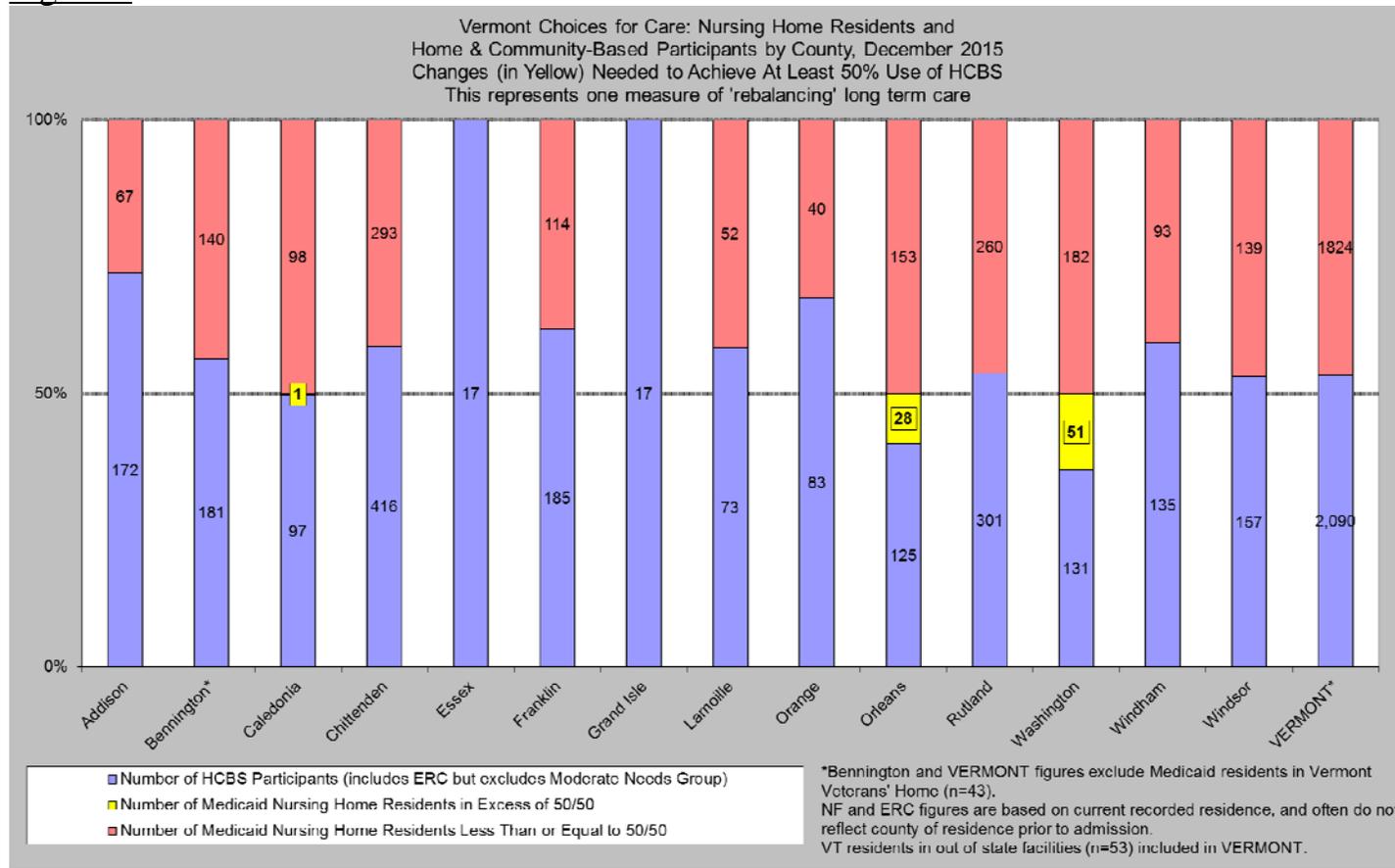


Figure 7 shows that enrollments in HCBS and ERC settings exceed enrollment in nursing homes, with the exception of three counties: Caledonia, Orleans, and Washington. (Note: residents of the Vermont Veterans' Home in Bennington County are excluded from this graph.)

Figure 7



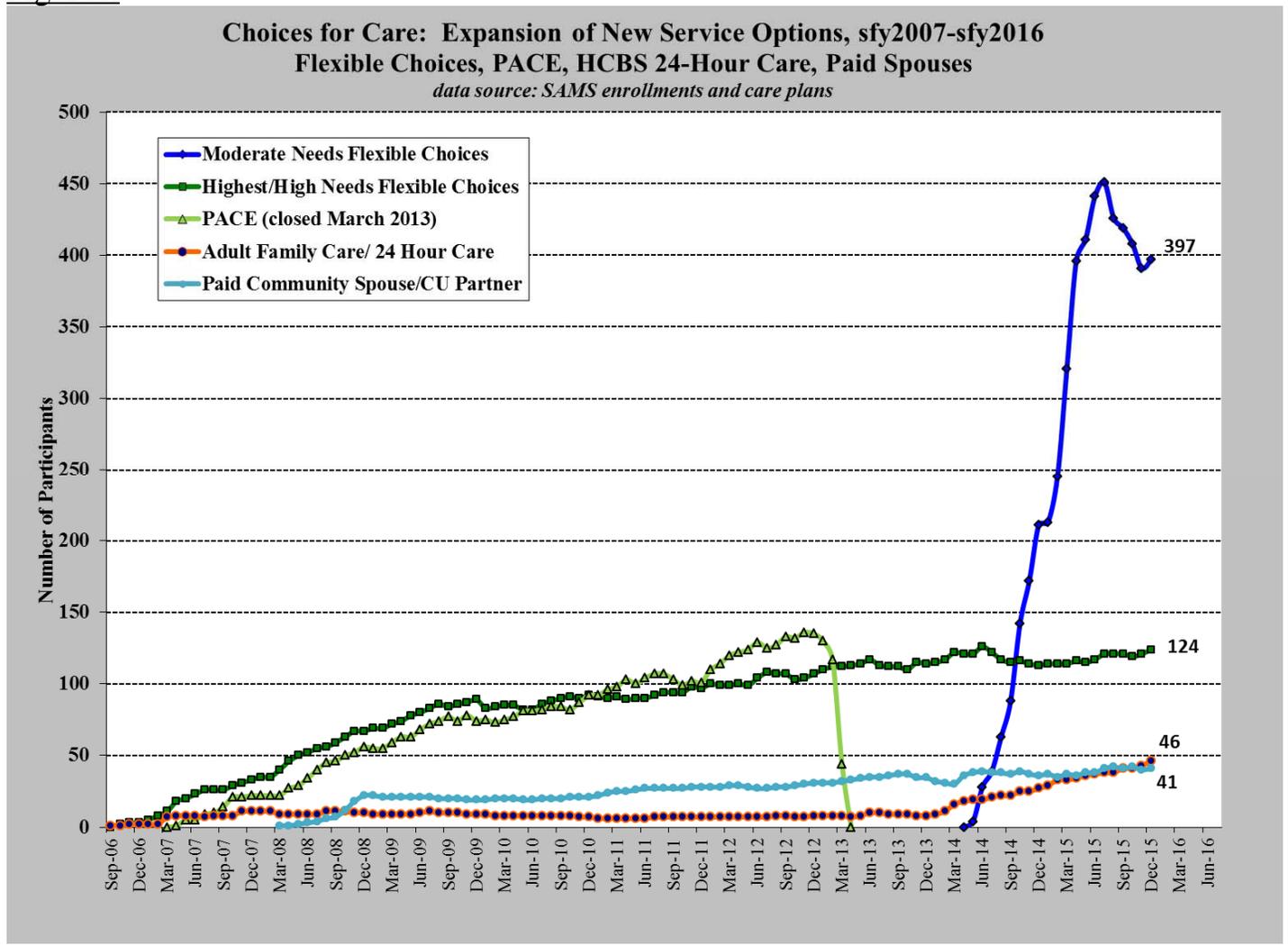
Data source: SAMS

4. Expand the range of service options

One of the goals of Choices for Care is to expand the range of service options available to participants. Since Choices for Care began, five new service options were developed. The Vermont PACE program closed its two sites (in Colchester and Rutland) in March 2013, leaving four remaining ‘new’ service options:

- Moderate Needs Flexible Choices: Implemented in sfy2014, intended to give participants more choice and control over the services that they receive.
- Highest/High Needs Flexible Choices: Implemented in sfy2006, intended to give participants more choice and control over the services that they receive.
- Adult Family Care/24 hour care: Implemented in sfy2008 and expanded in sfy2013, intended to give people access to 24-hour services in home settings.
- Paid Community Spouse/Civil Union Partner: Implemented in sfy2008, allowing people to employ spouses and civil union partners as paid caregivers.

Figure 8

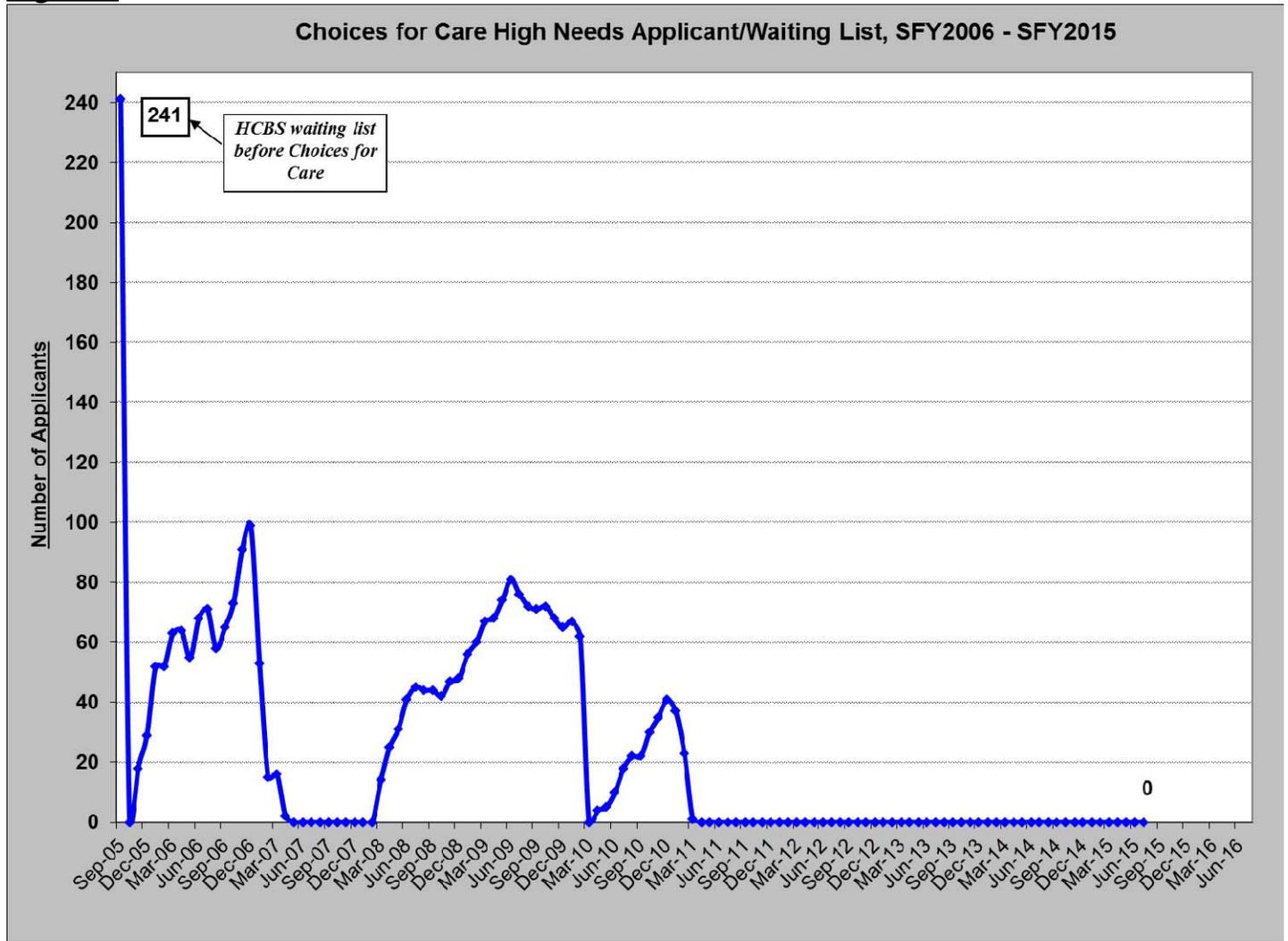


Data source: SAMS

5. Eliminate or Reduce 'High Needs' Waiting Lists

One of the goals of Choices for Care is to eliminate or reduce waiting lists. Choices for Care has eliminated the waiting list for people who meet 'High Needs' nursing home level of care criteria:

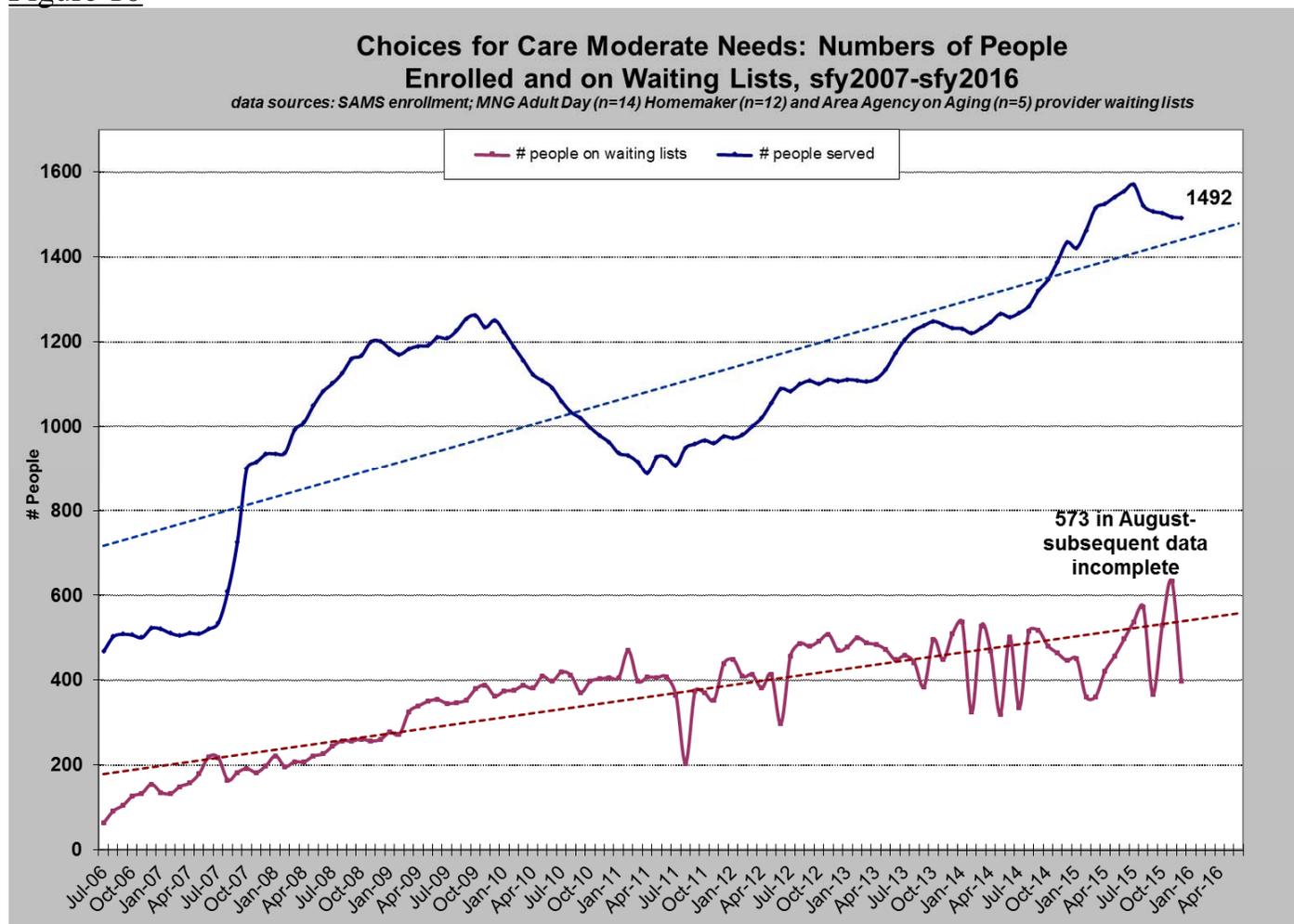
Figure 9



Data source: SAMS

Waiting lists do continue for applicants in the Moderate Needs Group, who do not meet nursing home level of care criteria. Many thousands of Vermonters are potentially eligible for this group, with services limited by available funding. As the number of people served has increased, the number of people on waiting lists has also increased. The numbers of people served and the numbers of people on waiting lists are positively correlated.

Figure 10



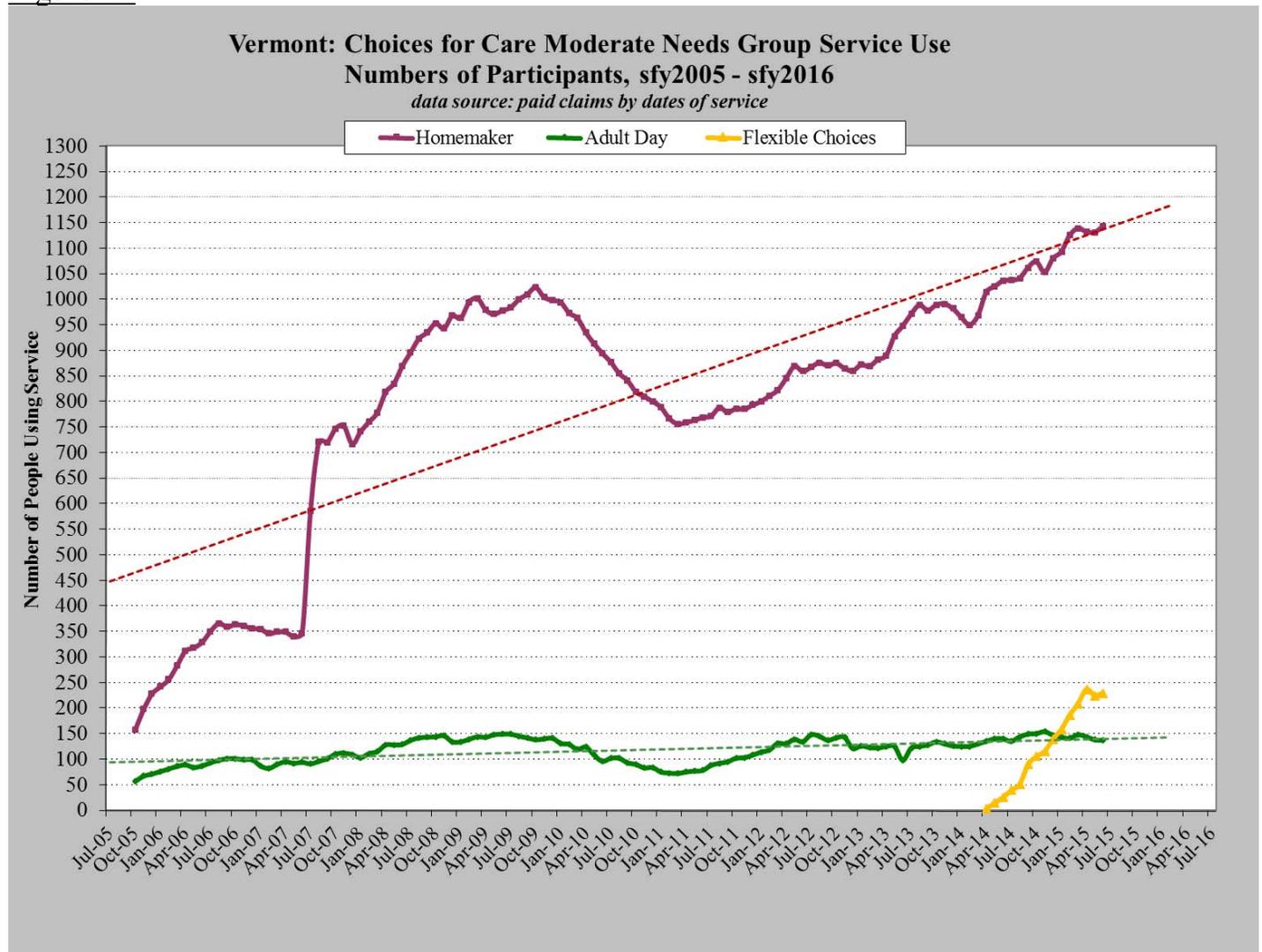
Data source: SAMS, MNG provider waiting lists

The eligibility requirements for Moderate Needs Group services are inclusive. As a result, the use of services is limited by the availability of funding, rather than by rigorous or restrictive functional and financial eligibility requirements. Because the number of potentially eligible people may be tens of thousands it is difficult to foresee circumstances in which a waiting list would be permanently eliminated.

Figure 10 illustrates the numbers of people using the two existing Moderate Needs Group Services (Homemaker and Adult Day) over time. A third ‘flexible choices’ service option was recently implemented, in which consumers have more flexibility in the use of funds, and may choose services other than adult day and homemaker. . This service should help to increase the total number of people served, but may not reduce waiting lists in the long term.

Note that the data source for this graph is paid claims, reflecting actual service delivery. These numbers are generally lower than SAMS enrollment (e.g. Figure 9 on page 11). Therefore, actual enrollment in these services may be higher than reflected here.

Figure 11



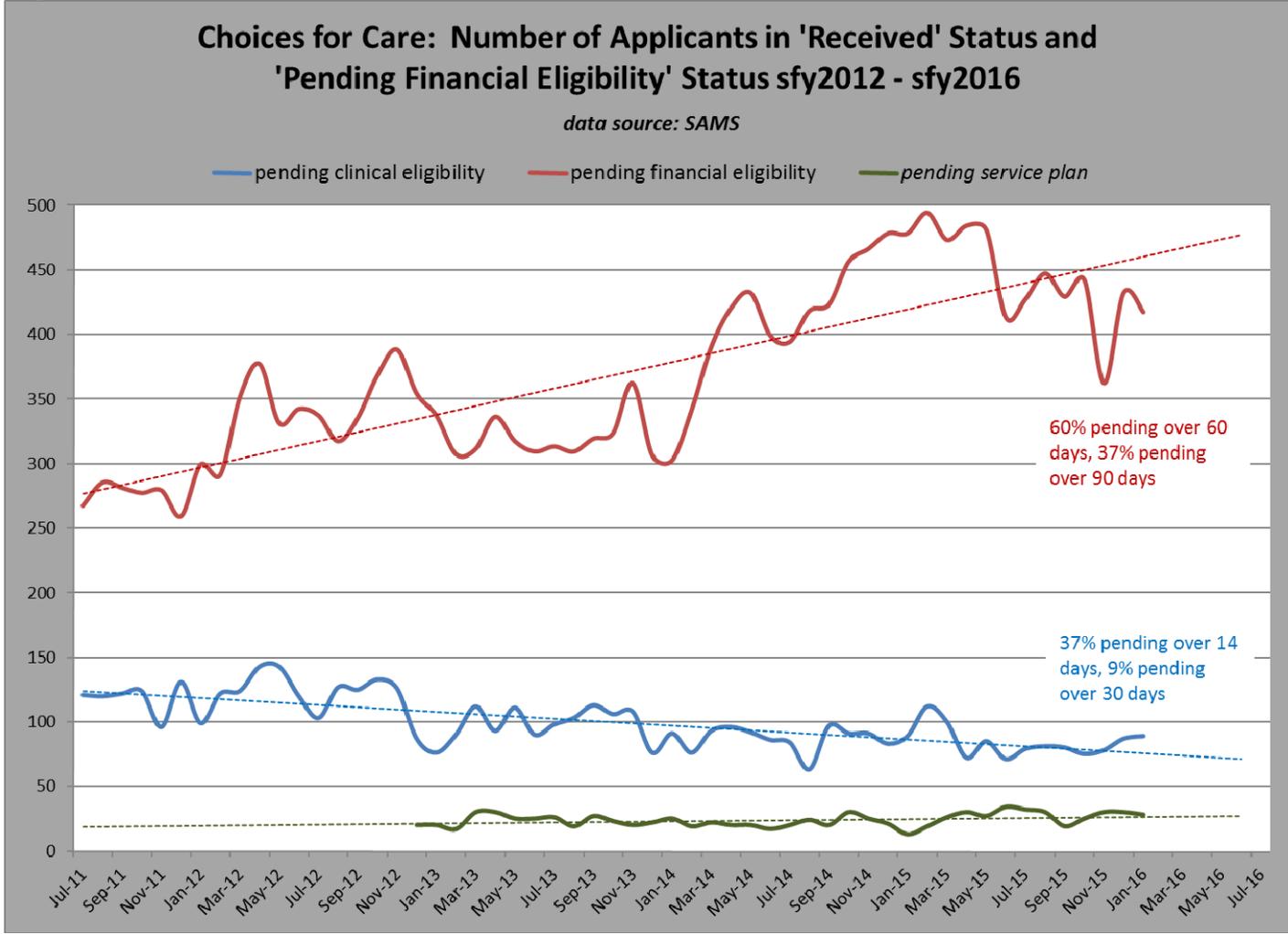
Data source: MMIS paid claims by dates of service

The number of people who are awaiting a DAIL clinical eligibility decision ('received' status) has decreased slightly over the past two years, while the number of people who have yet to receive a DCF financial eligibility decision ('pending' status) has increased.

DAIL has set a goal of making clinical eligibility decisions within 14 days of receiving an application. Recent data shows that 37% of the applicants awaiting a decision had waited more than 14 days.

Recent data shows that 60% of the applicants awaiting a financial eligibility decision had been waiting more than 60 days. Note that this does not include people whose eligibility decisions were made quickly. Some people awaiting a financial eligibility decision had yet to submit all of the information required by DCF to make an eligibility decision.

Figure 12



Data source: SAMS

Table 1 shows point-in-time DAIL performance in completing clinical eligibility determinations among the different regions of the state. Thirty-three applicants (37%) were waiting longer than 14 days, including 8 (9%) who were waiting longer than 30 days in four regions. The current time standard is 30 days (Choices for Care regulations).

Table 1: Point-in-time Completion of Clinical Eligibility Determinations for DAIL by Region

MUNICIPALITY	Total Clients	# of Clients <=14 Days Since Received	Percent	# of Clients 15 to 30 Days Since Received	Percent	# of Clients >=31 Days Since Received	Percent
Barre DAIL Office	10	7	70.00%	3	30.00%	0	0.00%
Bennington DAIL Office	13	2	15.38%	9	69.23%	2	15.38%
Brattleboro DAIL Office	5	5	100.00%	0	0.00%	0	0.00%
Burlington DAIL Office	21	9	42.86%	8	38.10%	4	19.05%
Hartford DAIL Office	4	2	50.00%	2	50.00%	0	0.00%
Morrisville DAIL Office	2	2	100.00%	0	0.00%	0	0.00%
Newport DAIL Office	5	5	100.00%	0	0.00%	0	0.00%
Rutland DAIL Office	14	12	85.71%	2	14.29%	0	0.00%
Springfield DAIL Office	2	0	0.00%	1	50.00%	1	50.00%
St. Albans DAIL Office	9	3	33.33%	5	55.56%	1	11.11%
St. Johnsbury DAIL Office	4	1	25.00%	3	75.00%	0	0.00%
Total	89	48	53.93%	33	37.08%	8	8.99%

Data source: SAMS

Figure 13:

Percentage of Choices for Care clinical eligibility determinations remaining incomplete after 30 days

Data Source: Harmony SAMS

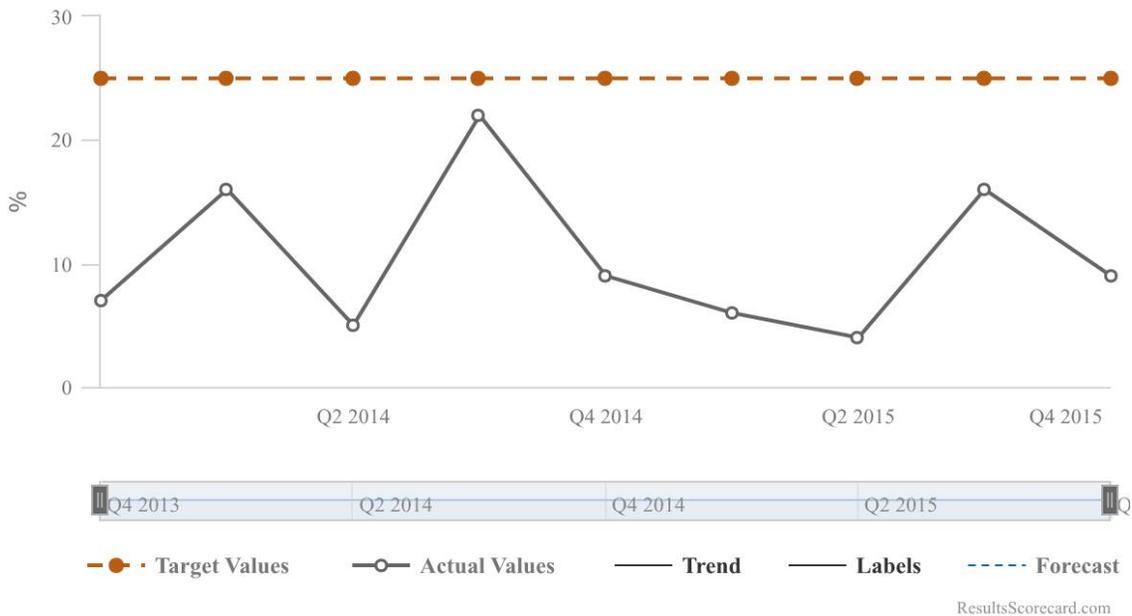


Table 2 shows point-in-time DCF performance in completing financial eligibility determinations among the different regions of the state. 256 applicants (60%) were waiting longer than 60 days, and 168 (40%) were waiting longer than 90 days. The current time standard is 90 days, although longer with extenuating circumstances.

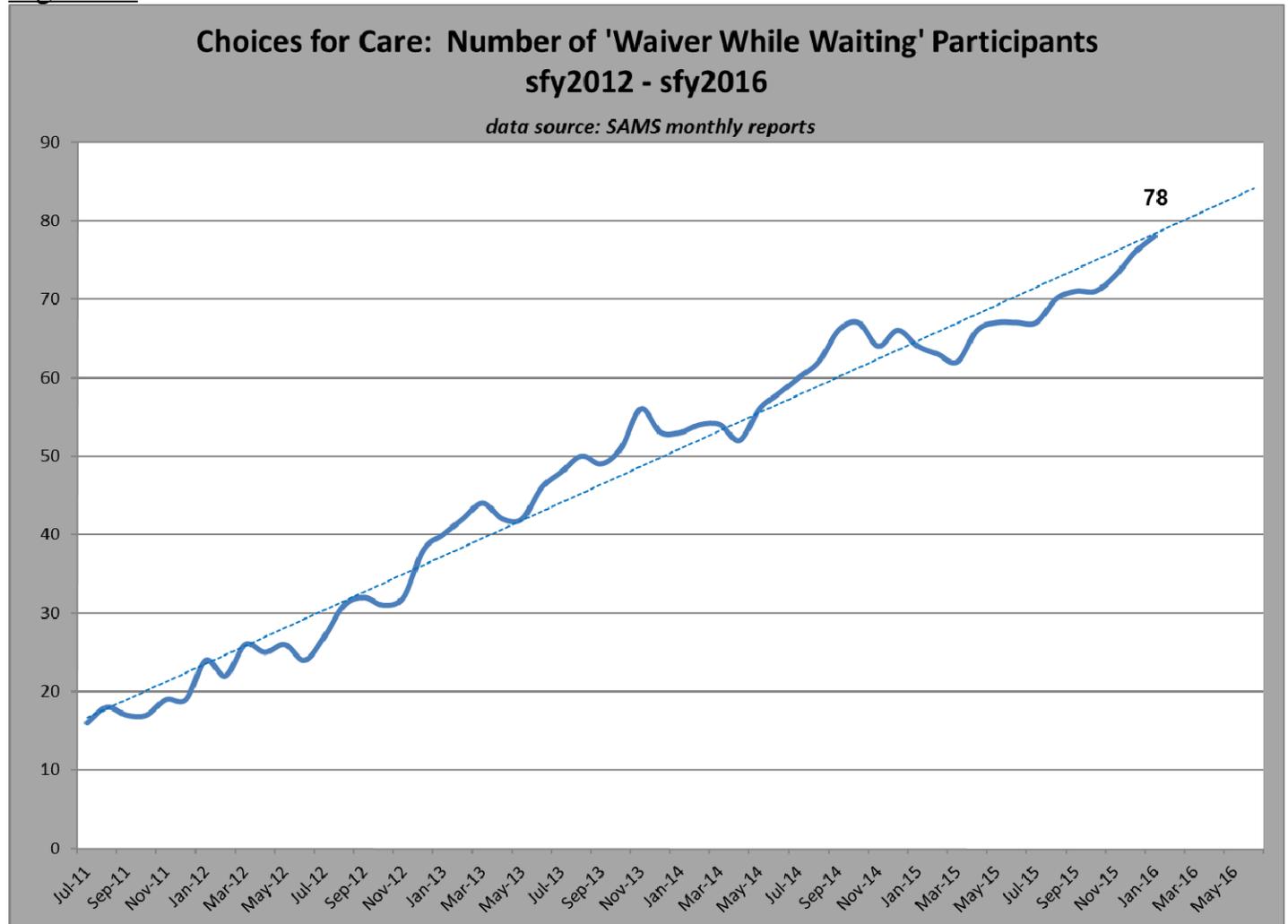
Table 2: Point-in Time Completion Rates for DCF Financial Eligibility Determination by Region

DAIL District Office (Municipality)	TOTAL CLIENTS	# of Clients <=14 Days Pending Medicaid	Percent	# of Clients 15-30 Days Pending Medicaid	Percent	# of Clients 31-60 Days Pending Medicaid	Percent	# of Clients 61-90 Days Pending Medicaid	Percent	# of Clients >=91 Days Pending Medicaid	Percent
Barre DAIL Office	29	0	0.00%	2	6.90%	9	31.03%	10	34.48%	8	27.59%
Bennington DAIL Office	42	0	0.00%	2	4.76%	7	16.67%	14	33.33%	19	45.24%
Brattleboro DAIL Office	38	2	5.26%	7	18.42%	11	28.95%	4	10.53%	14	36.84%
Burlington DAIL Office	65	1	1.54%	8	12.31%	22	33.85%	13	20.00%	21	32.31%
Hartford DAIL Office	36	0	0.00%	4	11.11%	9	25.00%	9	25.00%	14	38.89%
Middlebury DAIL Office	19	1	5.26%	2	10.53%	6	31.58%	5	26.32%	5	26.32%
Morrisville DAIL Office	17	0	0.00%	5	29.41%	4	23.53%	4	23.53%	4	23.53%
Newport DAIL Office	34	2	5.88%	4	11.76%	5	14.71%	7	20.59%	16	47.06%
Rutland DAIL Office	48	0	0.00%	4	8.33%	8	16.67%	9	18.75%	27	56.25%
Springfield DAIL Office	37	1	2.70%	7	18.92%	5	13.51%	10	27.03%	14	37.84%
St. Albans DAIL Office	27	0	0.00%	4	14.81%	11	40.74%	4	14.81%	8	29.63%
St. Johnsbury DAIL Office	25	0	0.00%	1	4.00%	12	48.00%	8	32.00%	4	16.00%
Total	417	7	1.68%	50	11.99%	109	26.14%	97	23.26%	154	36.93%

Data source: SAMS

Financial eligibility determinations can require months to complete. One strategy for improving access to services was to develop ‘Waiver While Waiting’. Applicants who appear to meet financial eligibility criteria (based on information submitted to the Economic Services Division) are able to access services before a formal financial eligibility decision is made. The number of people who are in ‘waiver while waiting’ status has increased over time:

Figure 14

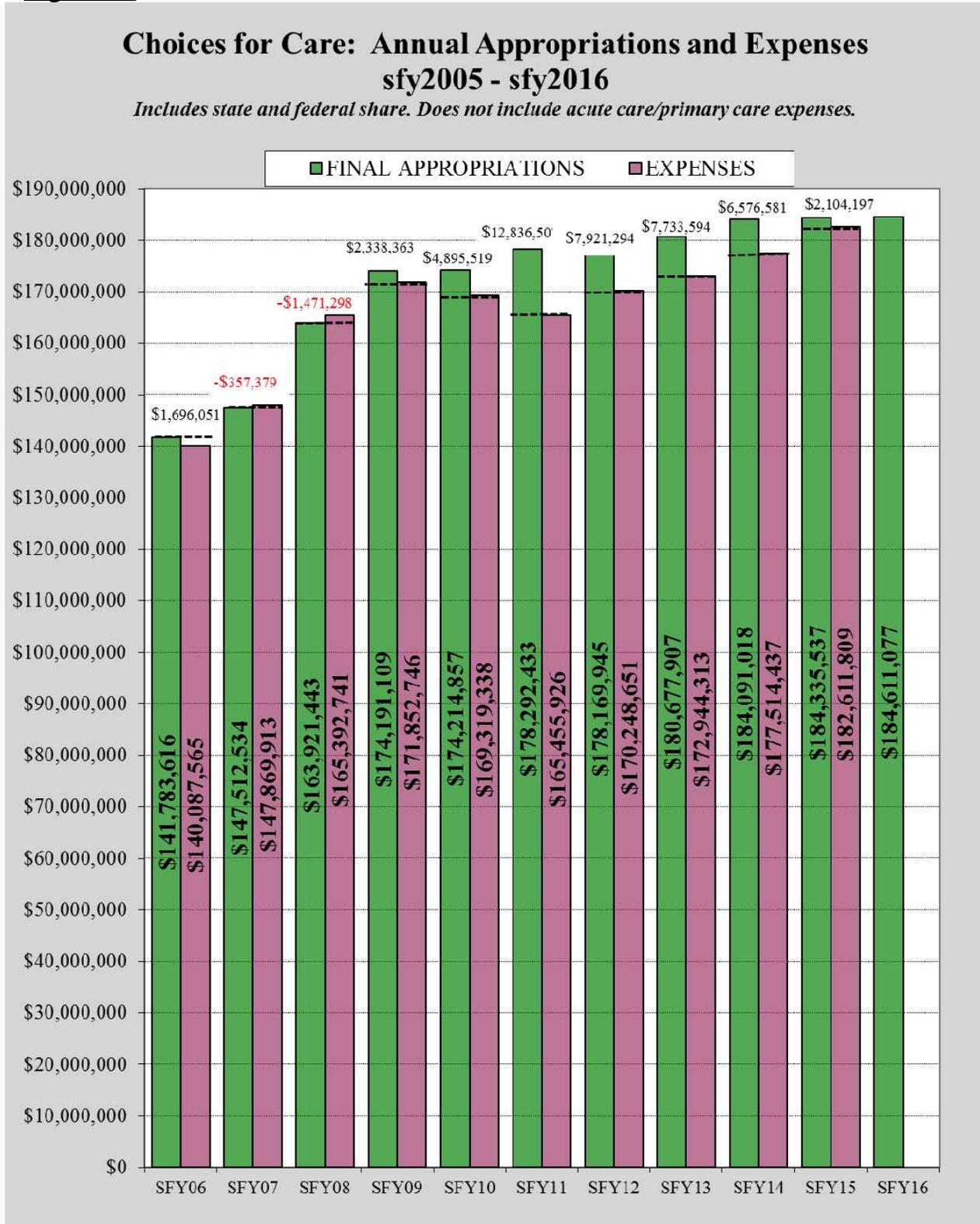


Data source: SAMS

6. Manage Spending to Available Funding

One of the goals of Choices for Care is to manage spending to the limits of available funding. Since SFY2008, Choices for Care spending has been less than the legislative appropriation:

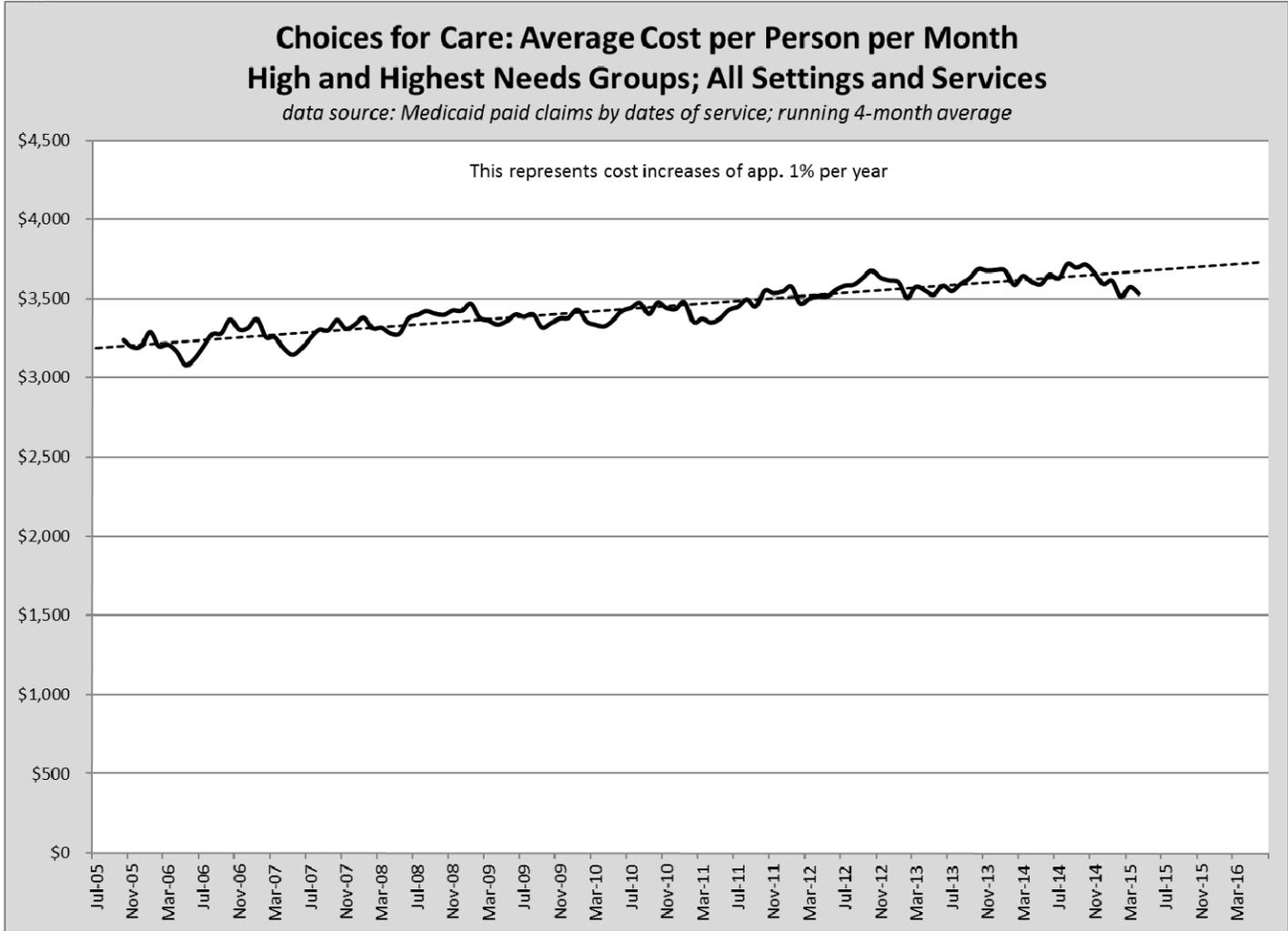
Figure 15



Data source: DAIL Business Office

This figure shows the average cost per person across all settings and services (excluding the Moderate Needs Group). The average cost per person has increased about 1% per year.

Figure 16



Data source: MMIS paid claims by dates of service

Savings (i.e. appropriated funds that were not expended within the fiscal year) are carried forward to support Choices for Care ‘reinvestments’.

The following reinvestments were made in sfy2016, using sfy2015 carry-forward funds of \$2,104,197:

Table 3

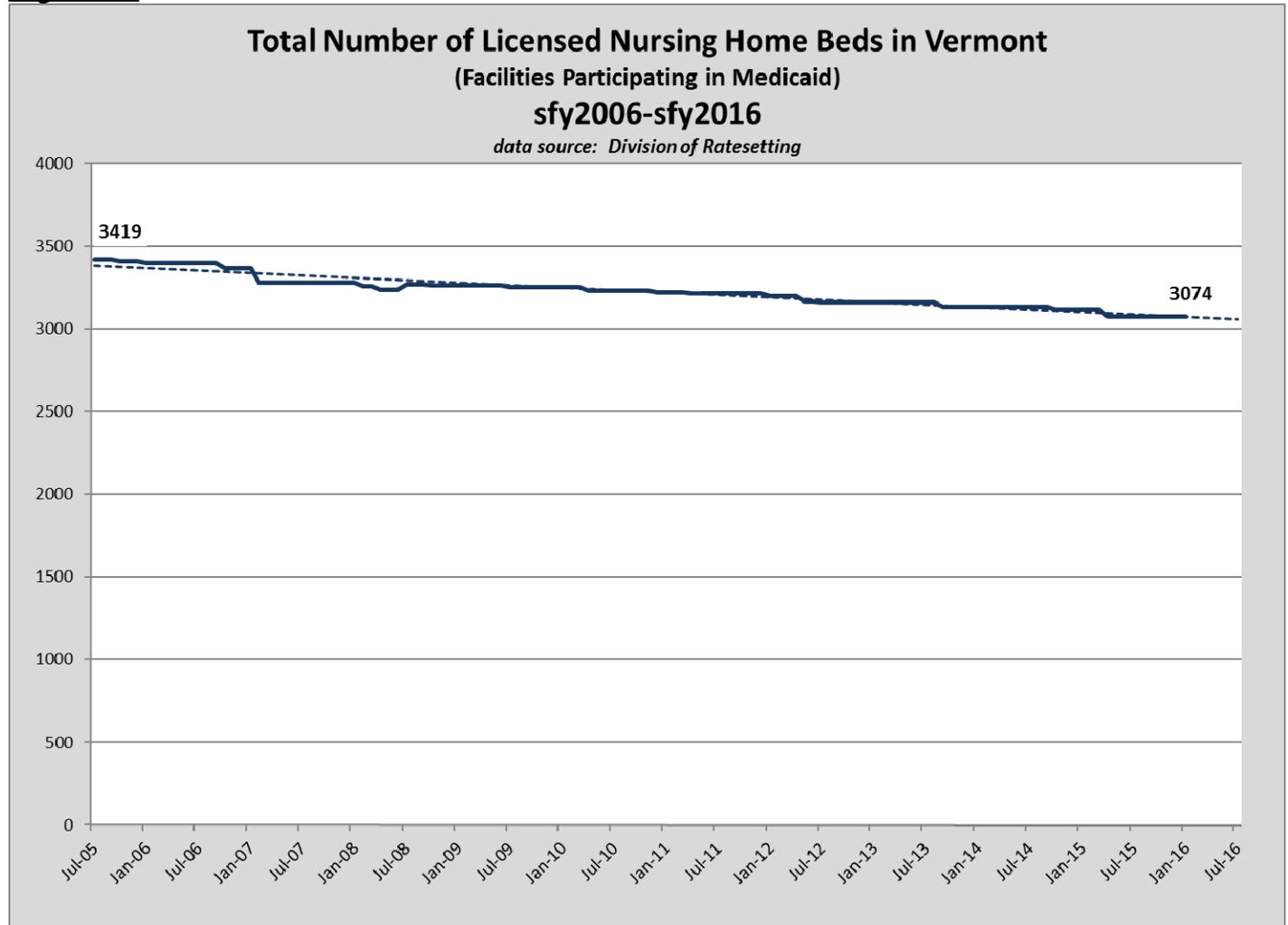
Choices for Care Reinvestments SFY2015 carry-forward for SFY2016: \$2,104,197	
\$1,241,748	Allocations to Moderate Needs Group providers to meet prevailing service utilization trends (includes \$179,000 to Area Agencies on Aging as base funding)
\$862,449	Contingency fund/reserve for additional enrollment and utilization in SFY2016
\$2,104,197	TOTAL

Choices for Care financial reports and other materials are available online at:
<http://www.dail.vermont.gov/dail-publications>

7. Ensure an adequate supply of nursing home beds

While one goal of Choices for Care is to ‘shift the balance’, another goal is to ensure continued access to an adequate supply of high-quality nursing homes. The number of nursing home beds in Vermont has decreased:

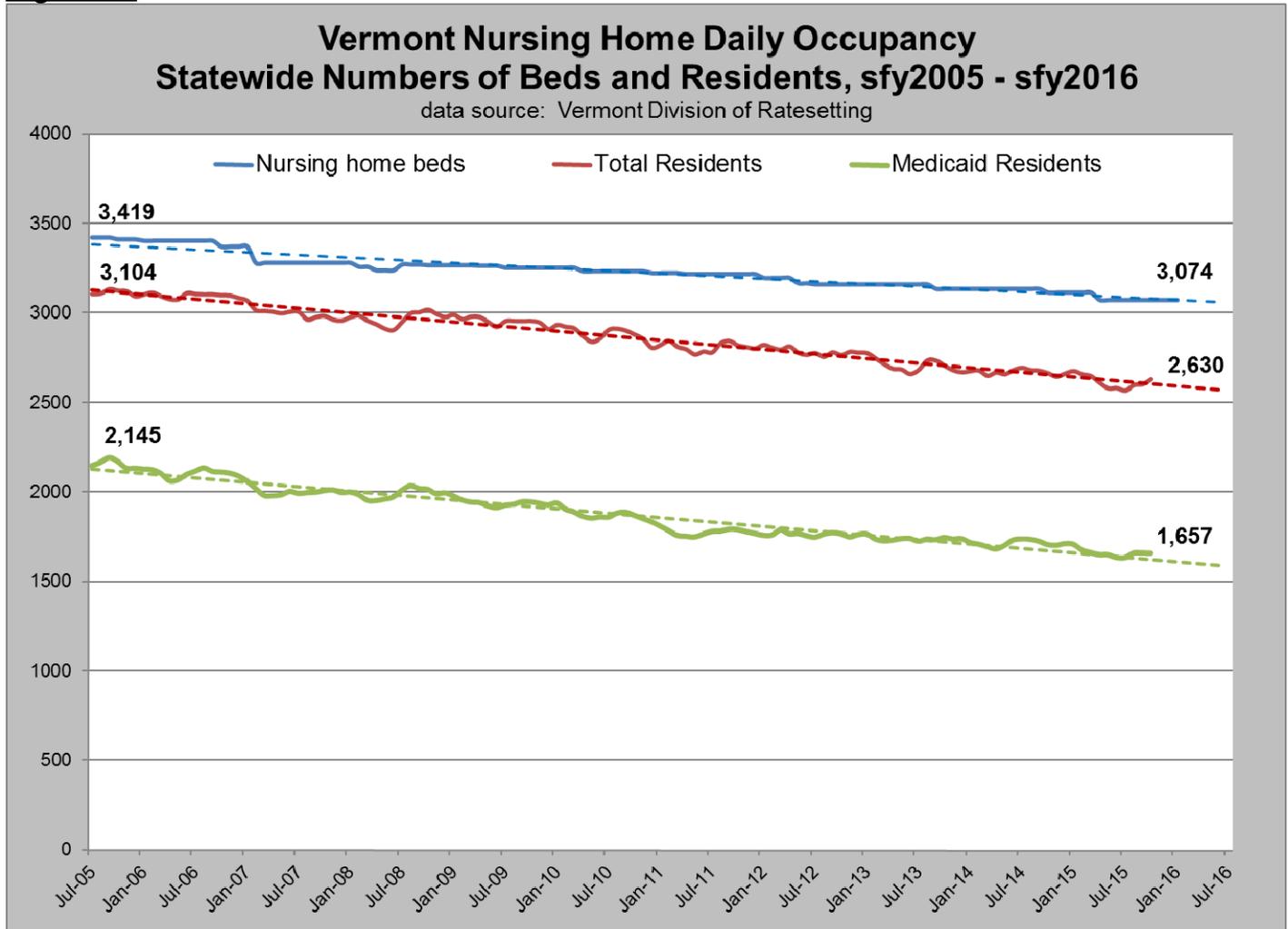
Figure 17



Data source: AHS Division of Ratesetting

While fewer people are using these nursing home beds:

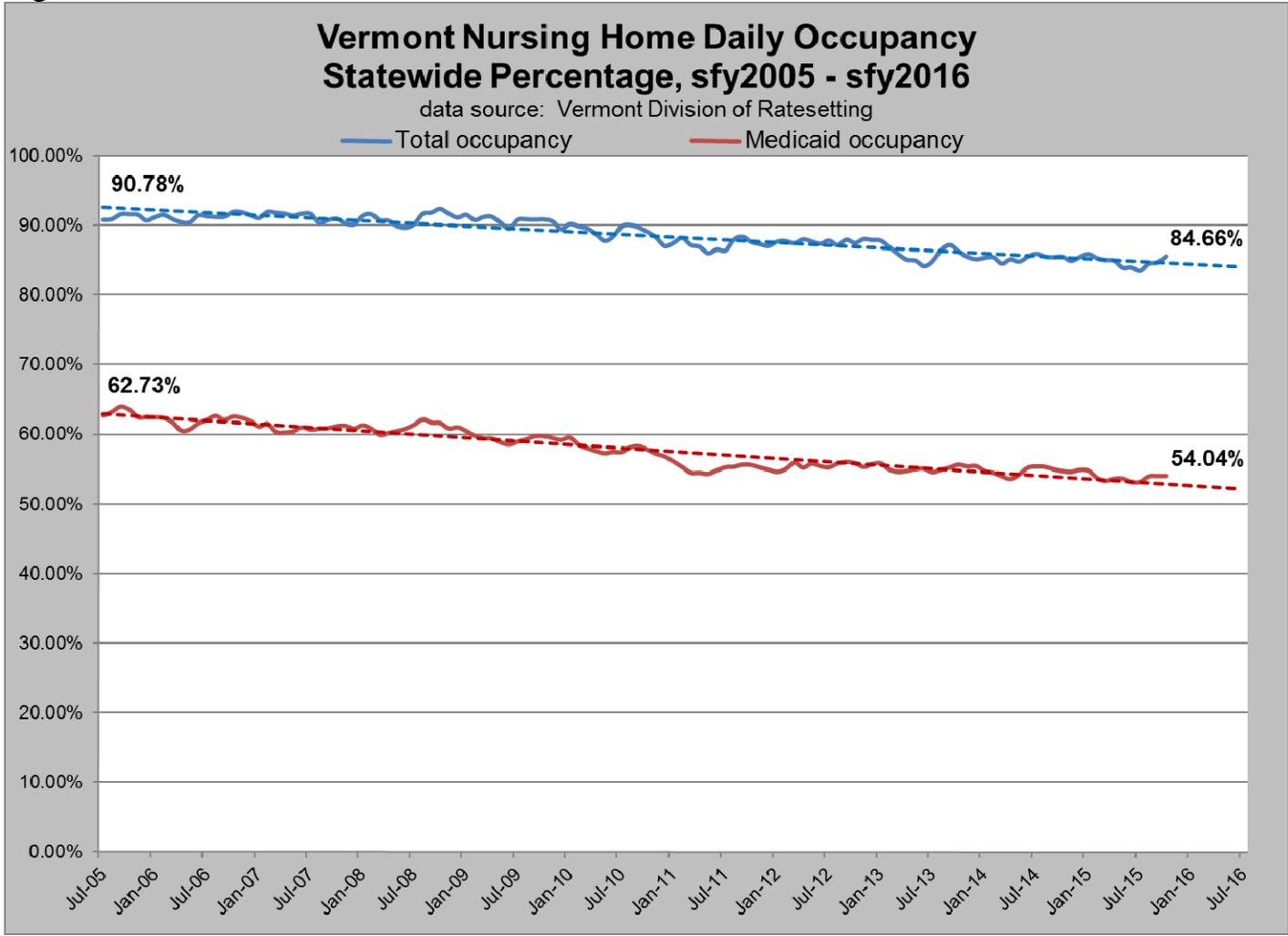
Figure 18



Data source: AHS Division of Ratesetting

With fewer people in fewer beds, nursing home occupancy rates have decreased. Since Choices for Care began, the total occupancy of Vermont nursing homes has decreased from about 92% to about 85%. The percentage of residents of Vermont nursing homes using Medicaid as primary payer has decreased from about 70% to about 64%.

Figure 19

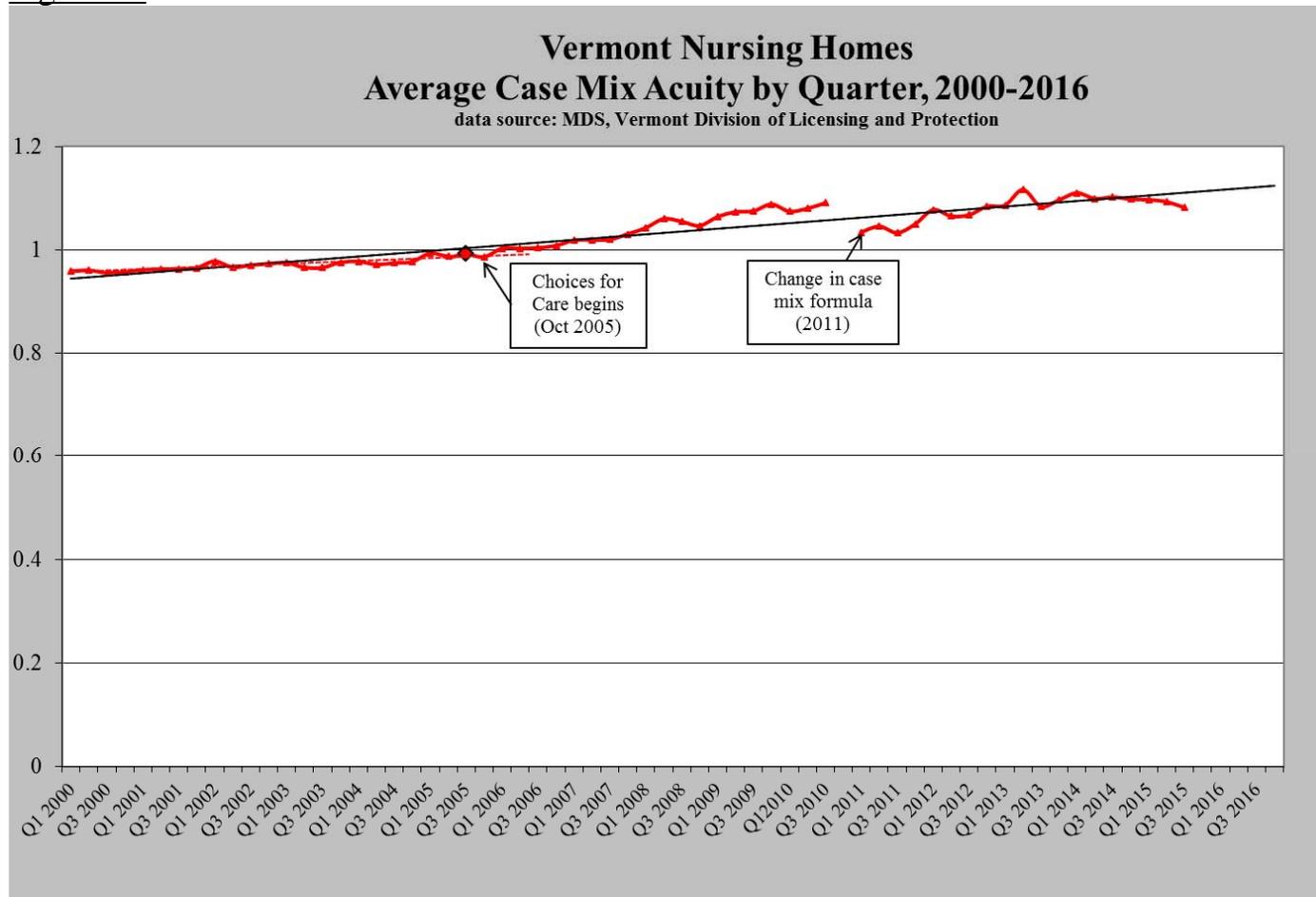


Data source: AHS Division of Ratesetting

This suggests that nursing home beds are unused and available for the people who want to use them. However, some facilities tend to be full or close to full, and some people with challenging needs do have difficulty in accessing nursing homes.

As the number of people in nursing homes has decreased, the acuity of the people who use nursing homes has increased. Because the case-mix measure of acuity does not give heavy weight to cognitive impairment or behavioral support needs, it is possible that the case mix scores do not adequately measure the needs of an increasing number of people with cognitive impairments in Vermont nursing homes.

Figure 20



Nursing home occupancy varies by facility and by county. Details regarding the occupancy of individual nursing homes are available at:

<http://www.dail.vermont.gov/dail-publications>.

Nursing home quality ratings are available on the CMS website:

<http://www.medicare.gov/NursingHomeCompare/search.aspx?bhcp=1>

These ratings suggest that the quality of services at Vermont nursing homes is good.

The results of Vermont licensing surveys of individual nursing homes are available online at:

<http://www.dlp.vermont.gov/license-survey-nursing>

8. Ensure that services are of high quality and support individual outcomes

The results of surveys of HCBS participants are generally positive. Through surveys, a large majority of participants report positive aspects of services:

Figure 21

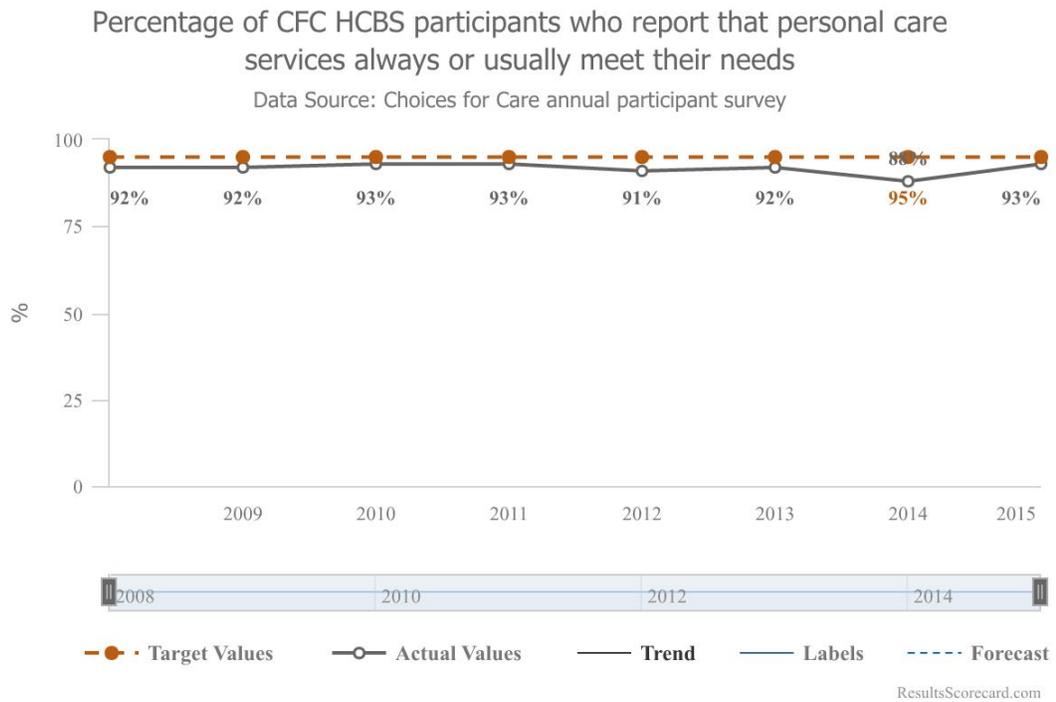


Figure 22

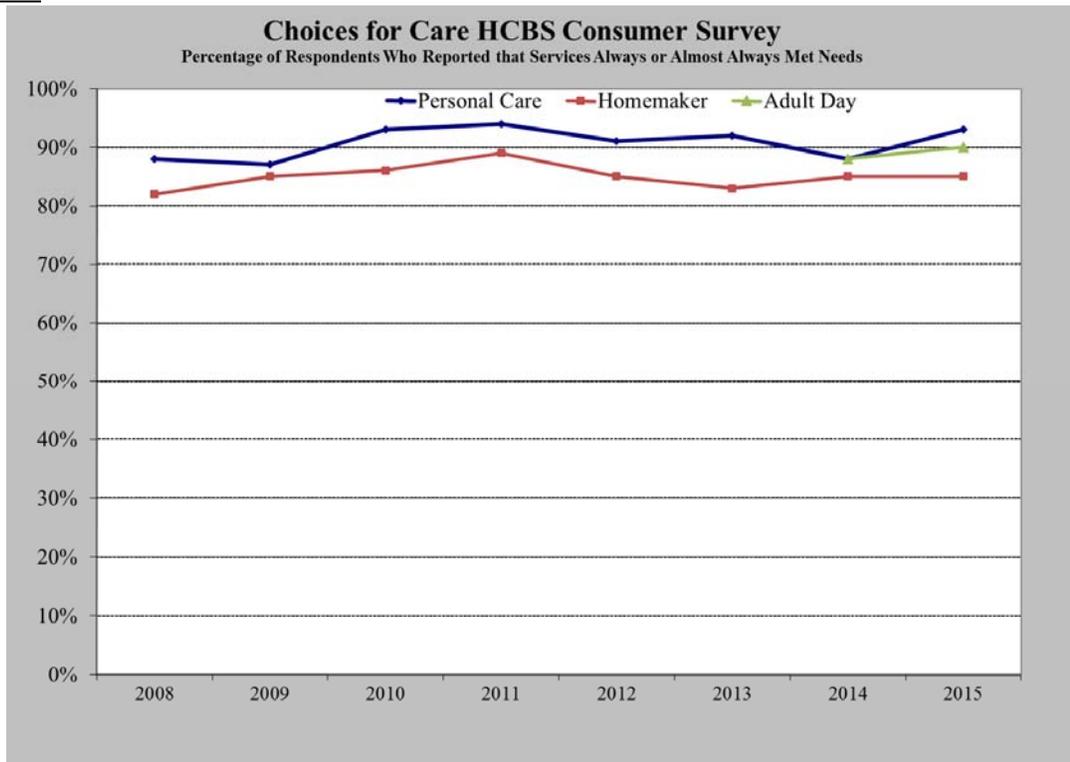
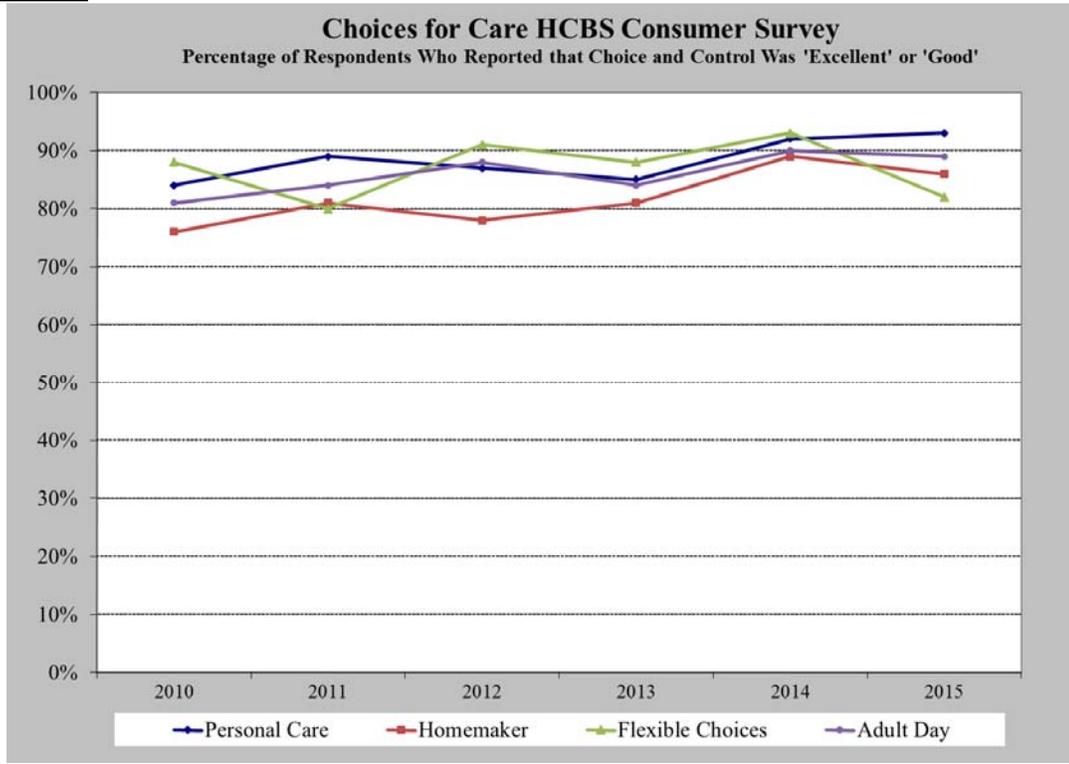
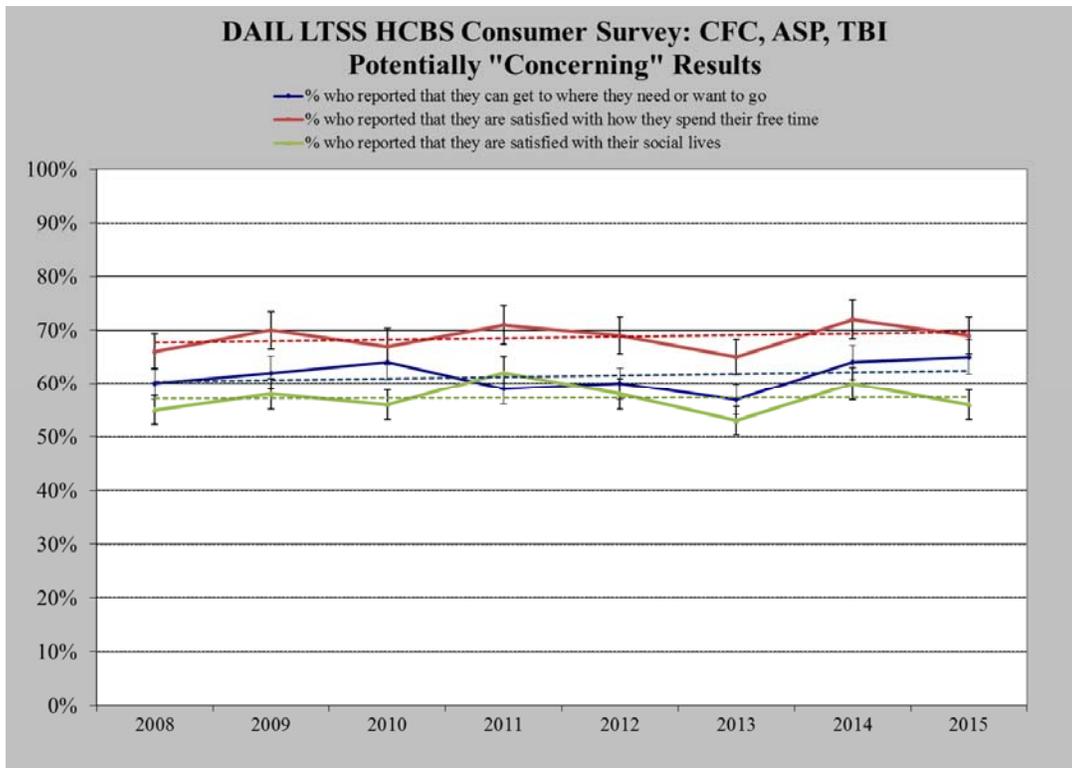


Figure 23



The surveys also suggest some opportunities for improvement:

Figure 24

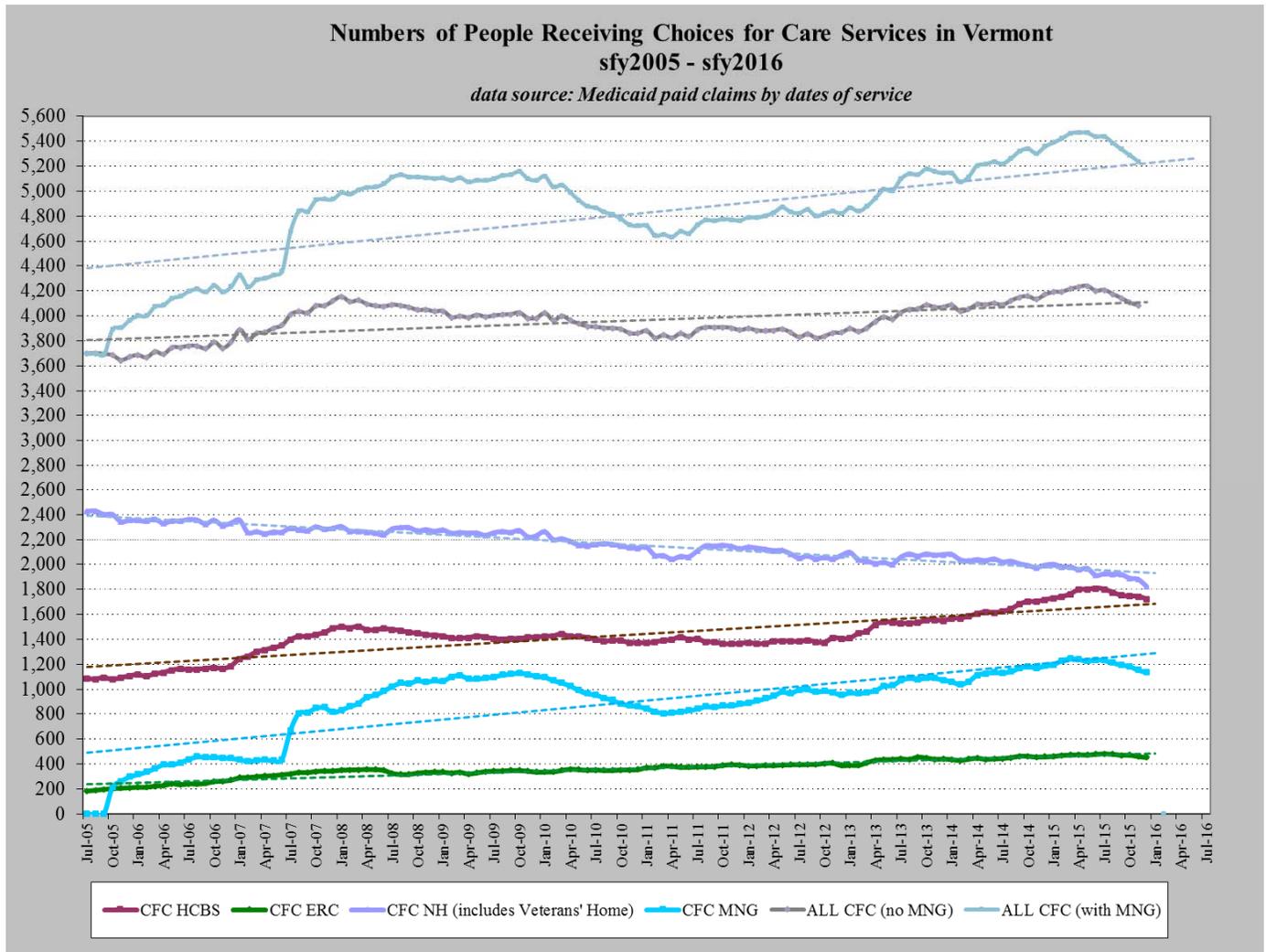


Consistent with previous recommendations from the Vermont state auditor and the independent evaluators, DAIL is working to develop methods of collecting comparable survey information from residents of nursing homes and other licensed facilities.

10. Other data

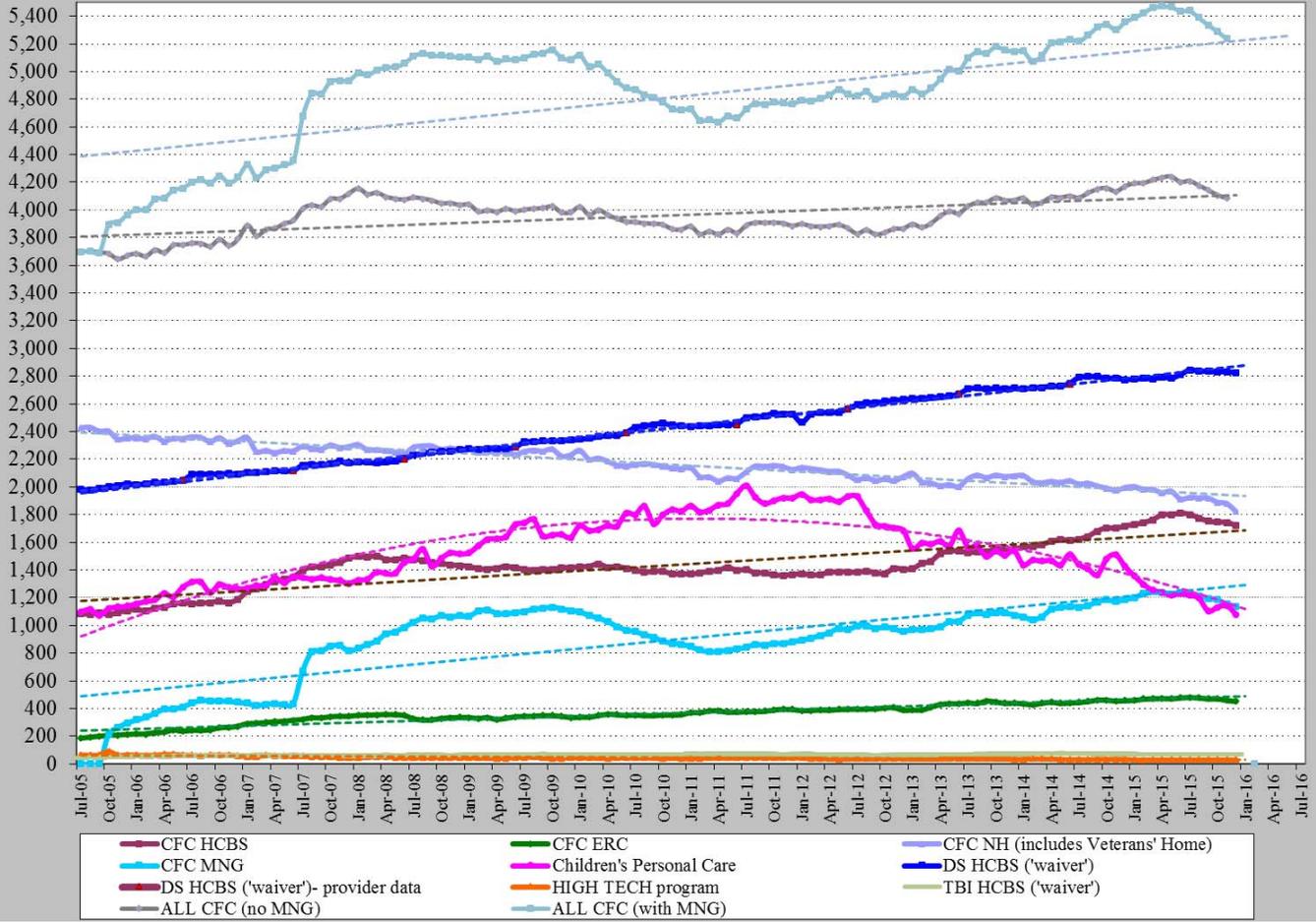
Summaries of recent expenses are produced at the request of the Vermont legislature. This information is posted on the DAIL website at <http://dail.vermont.gov/dail-publications>, along with other relevant information.

The graphs below show the use of different DAIL services among Vermont counties, with significant variation among the counties.



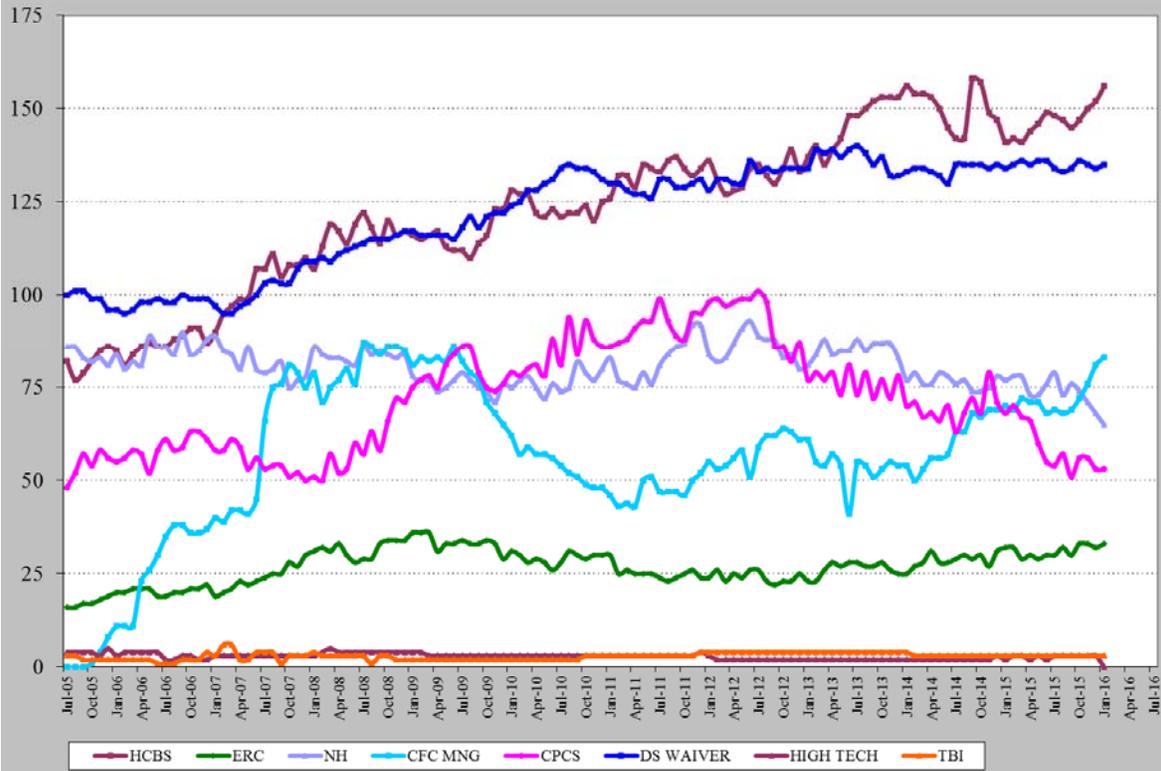
Numbers of People Receiving Selected Services in Vermont sfy2005 - sfy2016

data source: Medicaid paid claims by dates of service



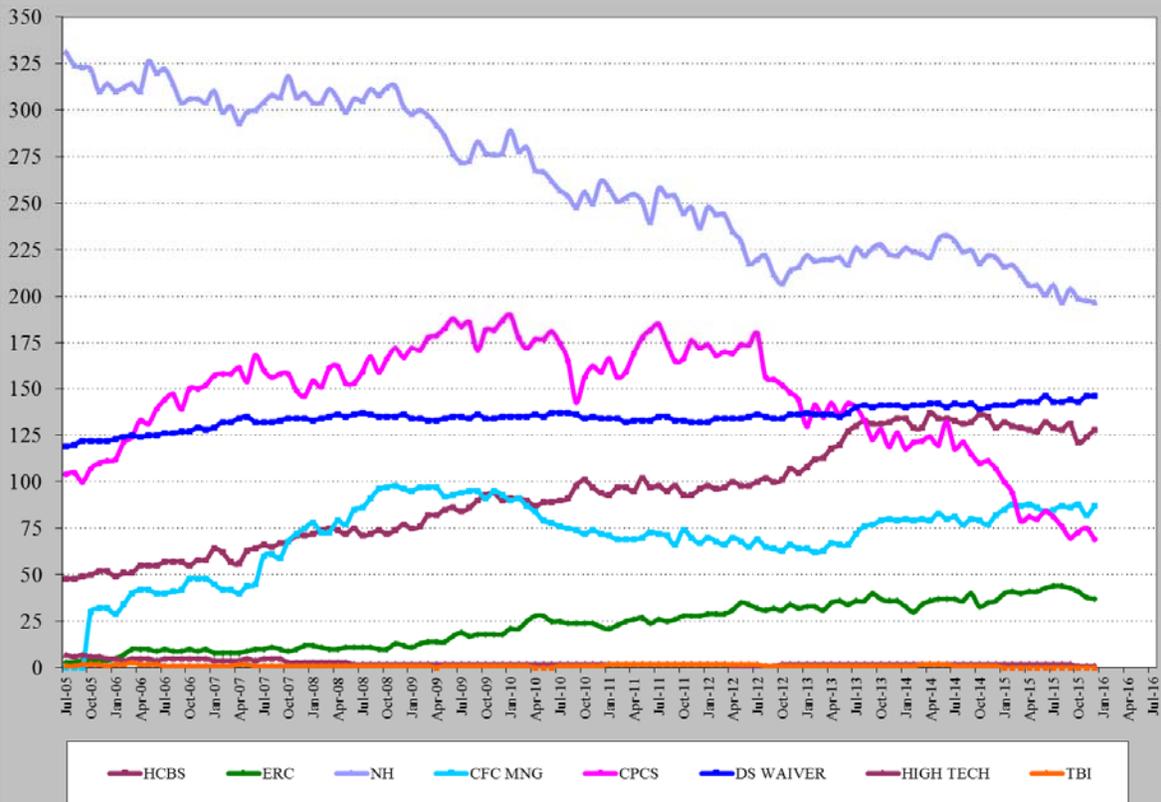
**Numbers of People Receiving Selected Services in Addison County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



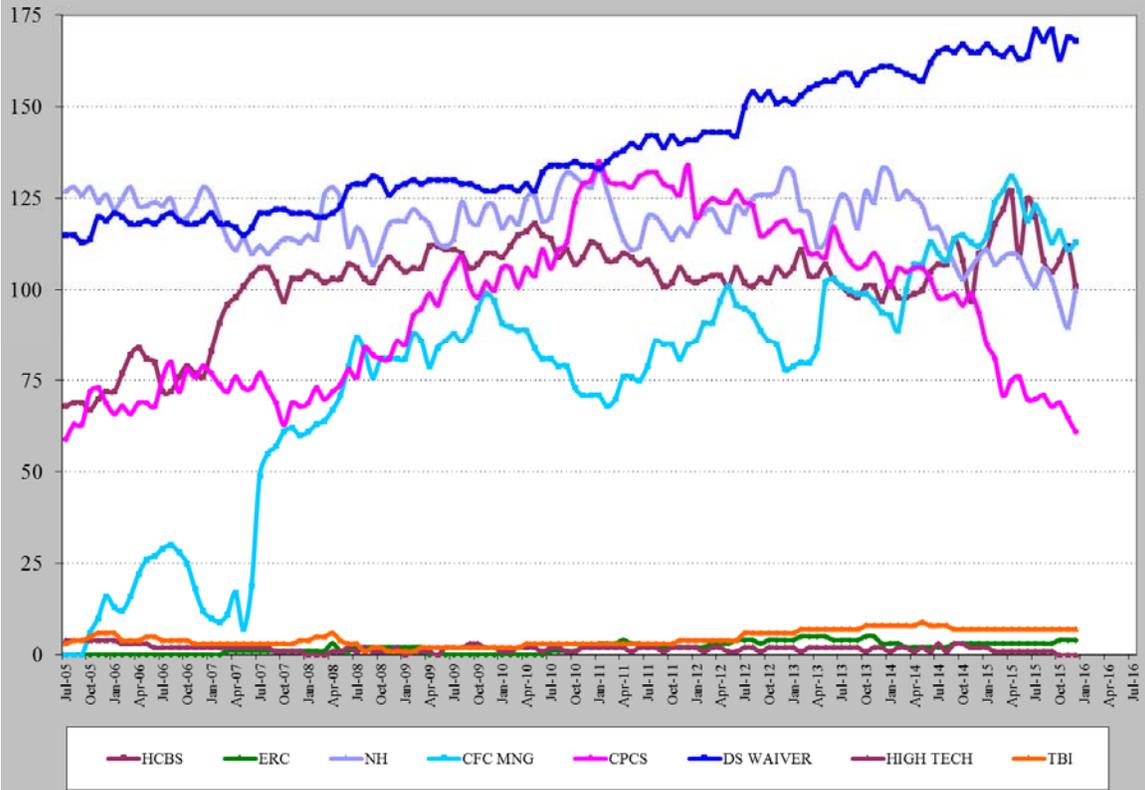
**Numbers of People Receiving Selected Services in Bennington County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service (includes Vermont Veterans Home)



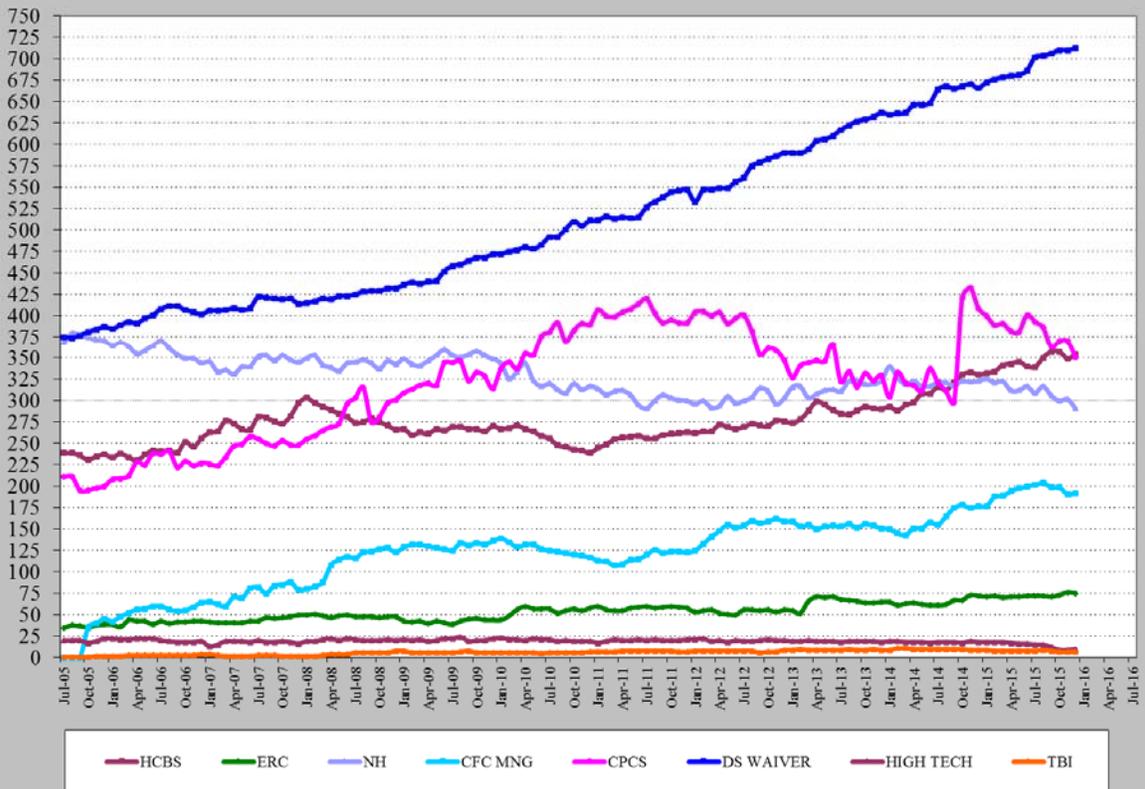
**Numbers of People Receiving Selected Services in Caledonia County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



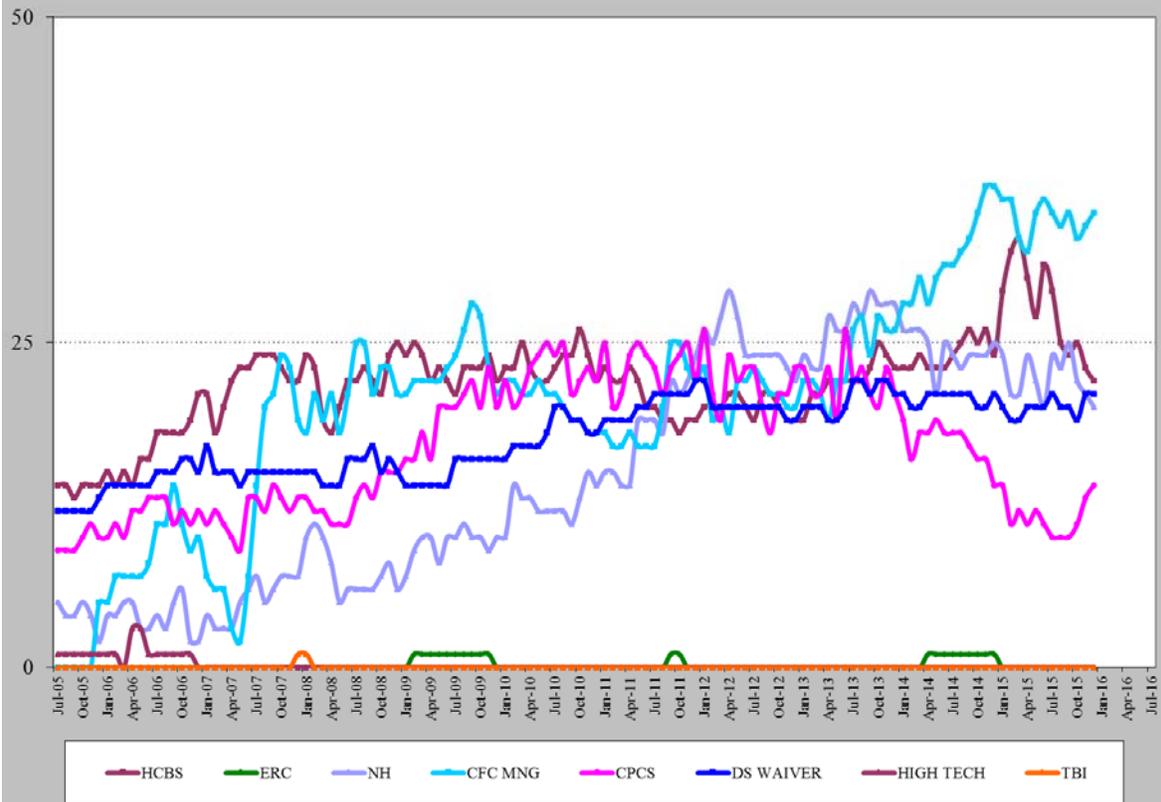
**Numbers of People Receiving Selected Services in Chittenden County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



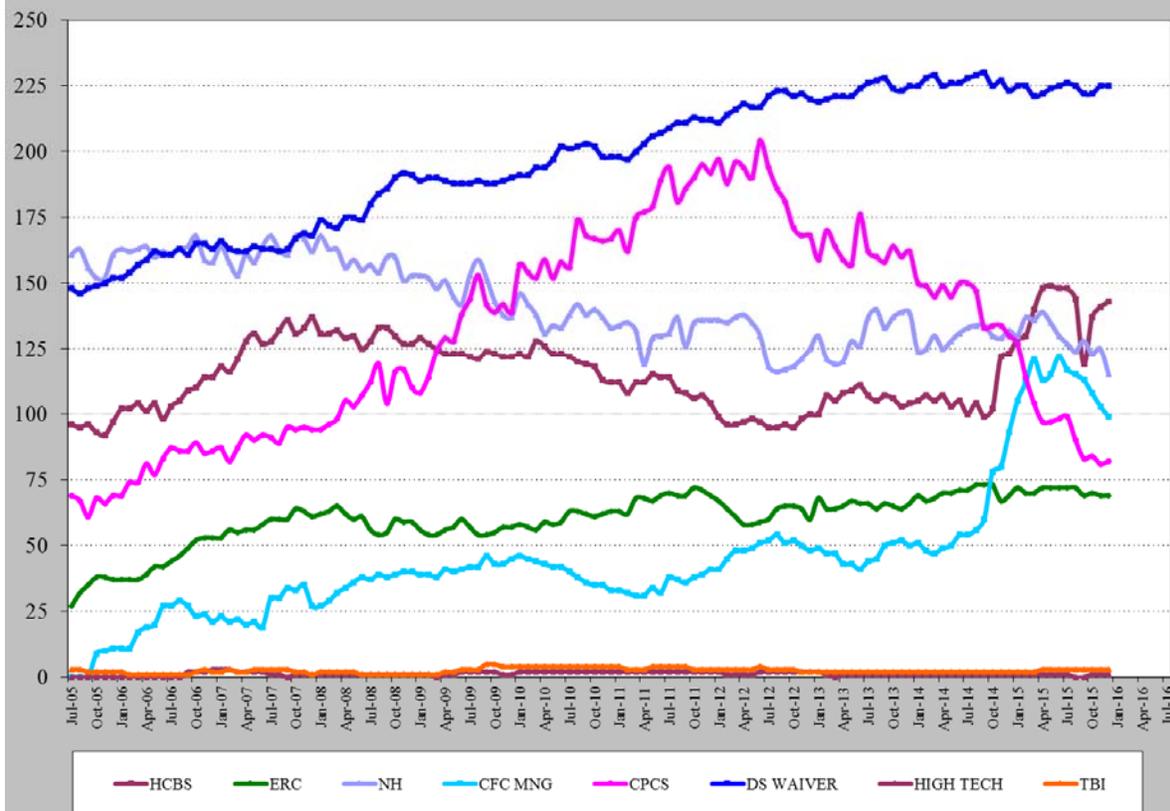
**Numbers of People Receiving Selected Services in Essex County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



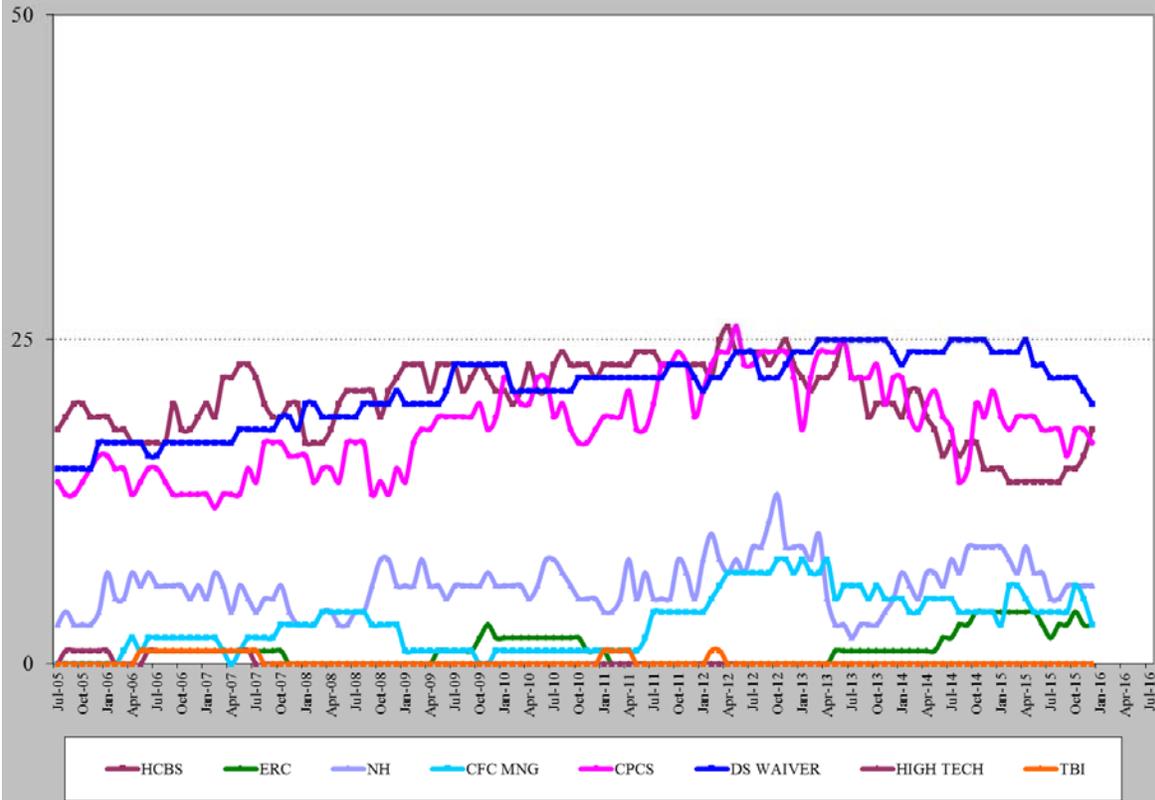
**Numbers of People Receiving Selected Services in Franklin County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



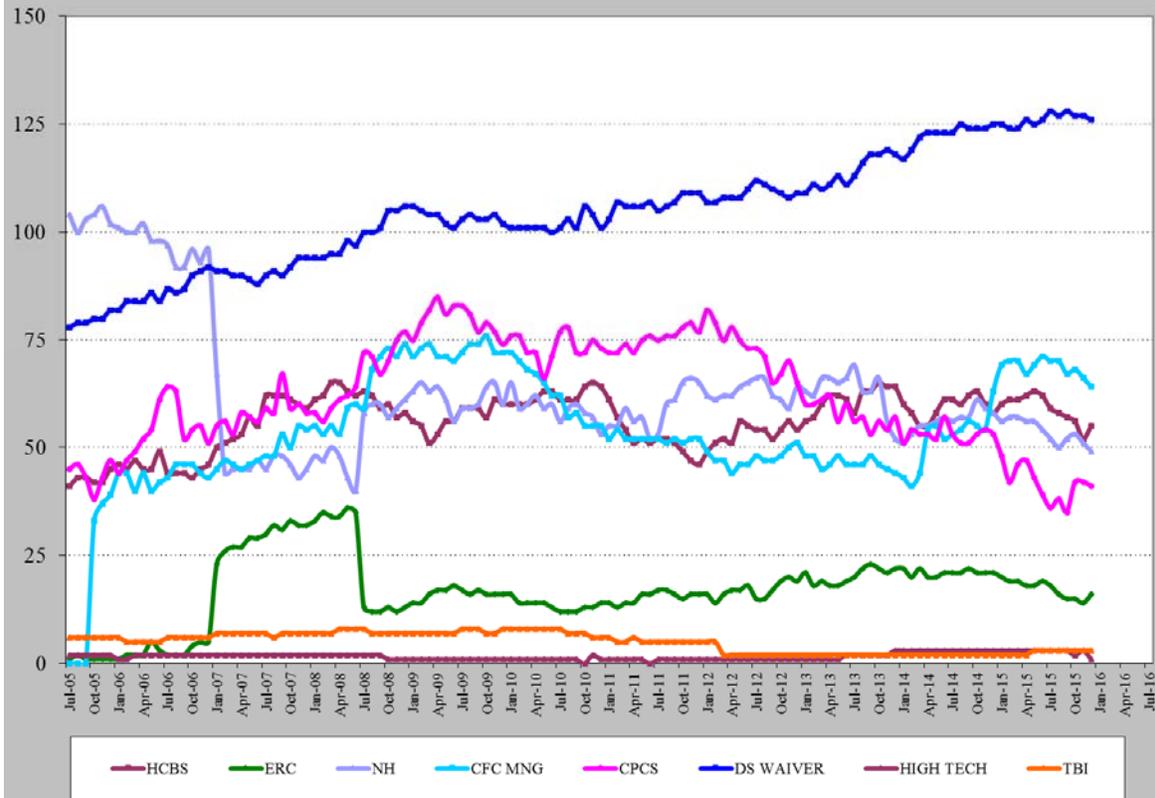
**Numbers of People Receiving Selected Services in Grand Isle County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



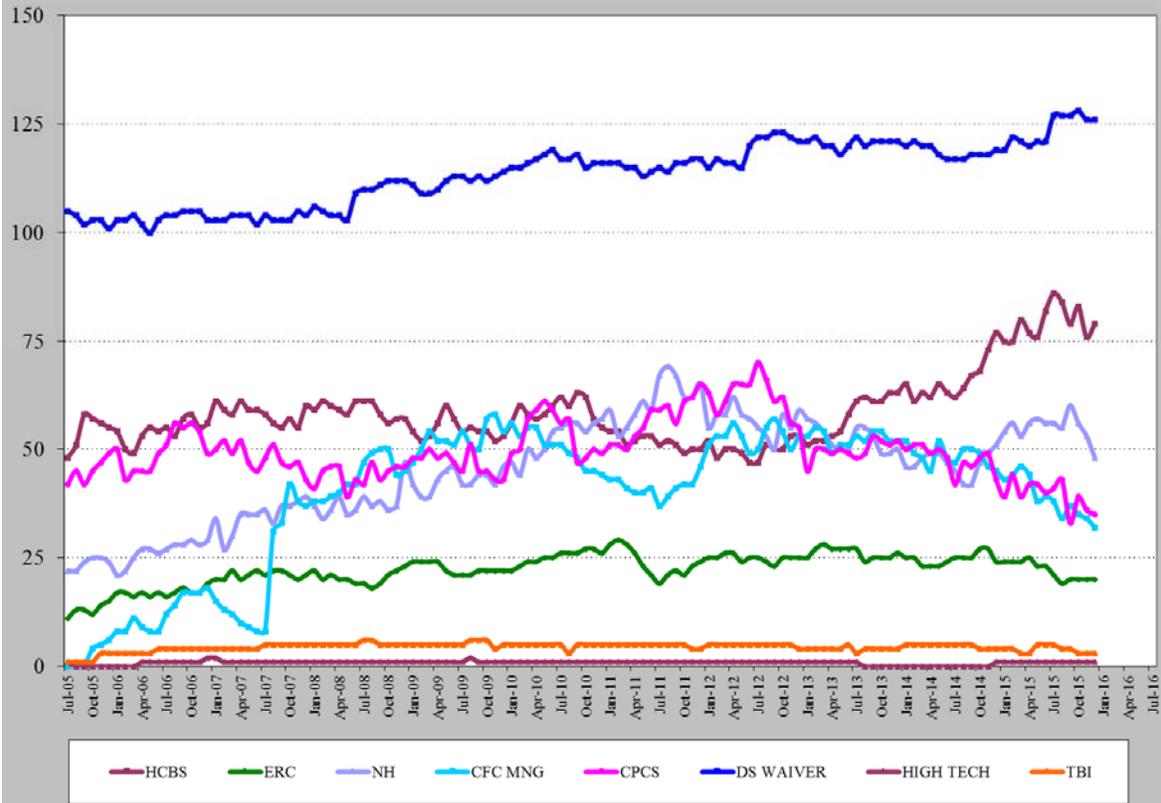
**Numbers of People Receiving Selected Services in Lamoille County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



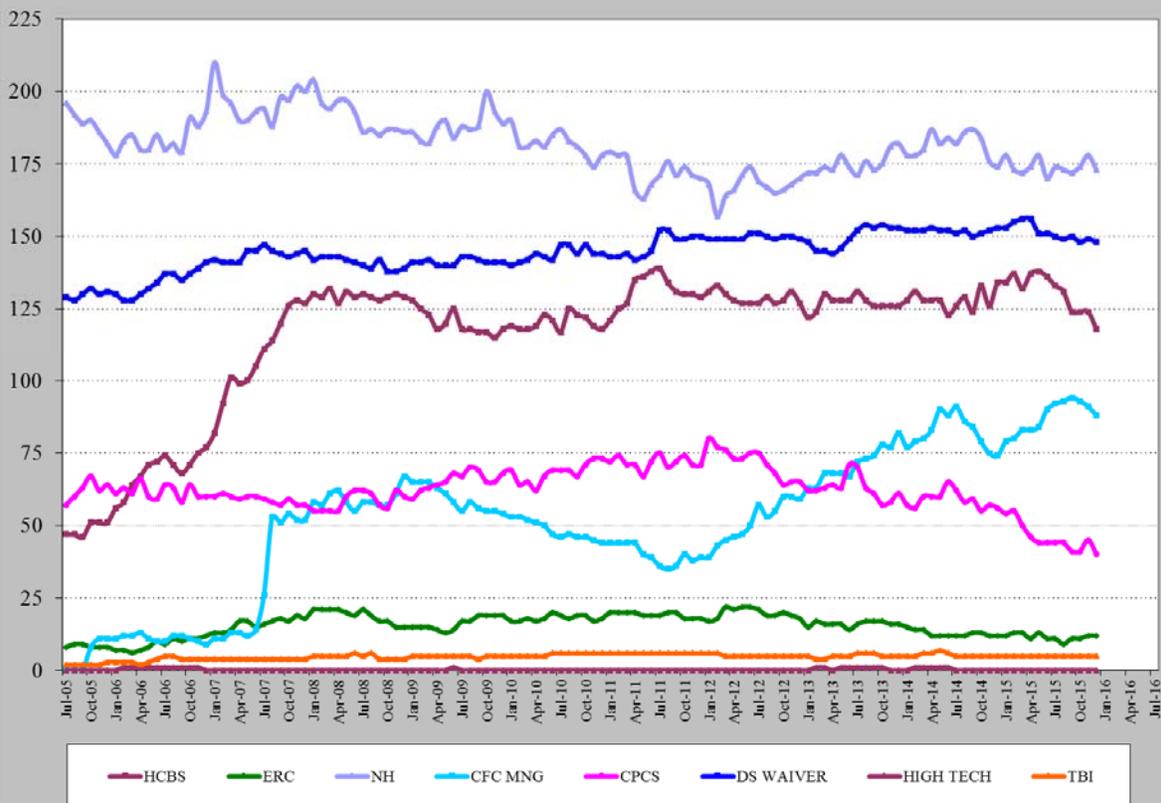
**Numbers of People Receiving Selected Services in Orange County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



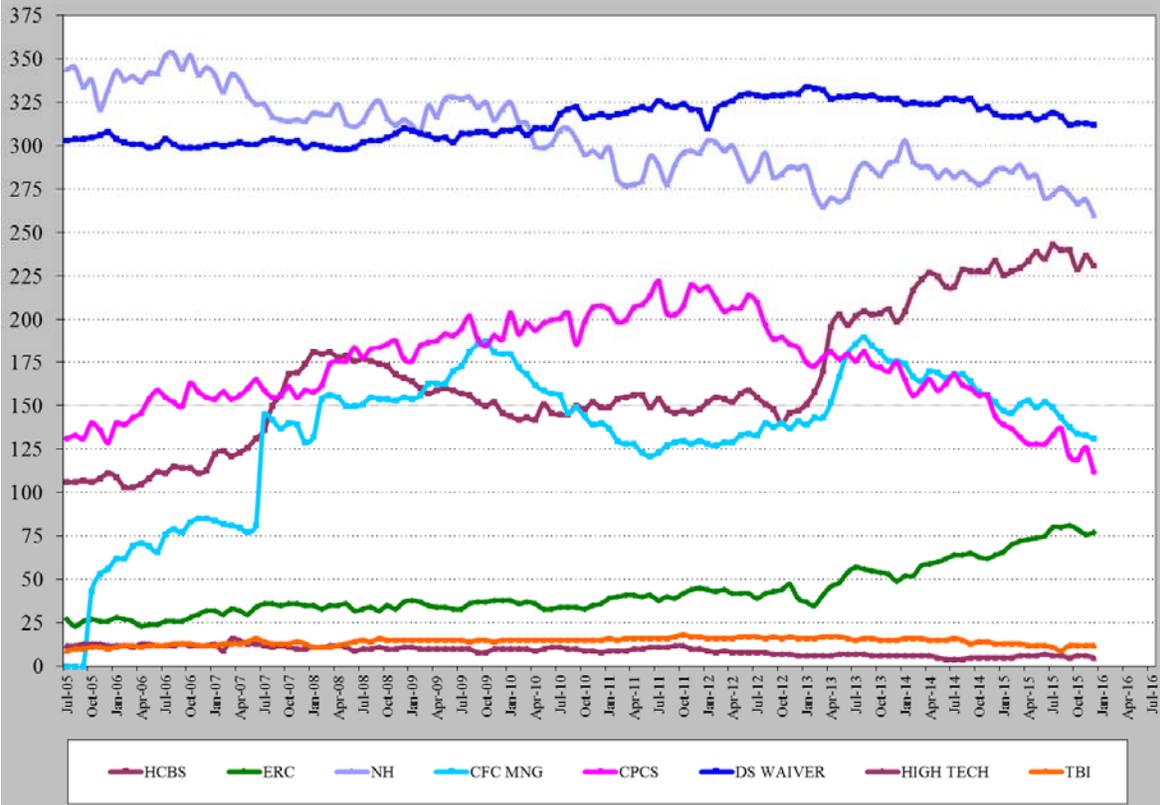
**Numbers of People Receiving Selected Services in Orleans County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



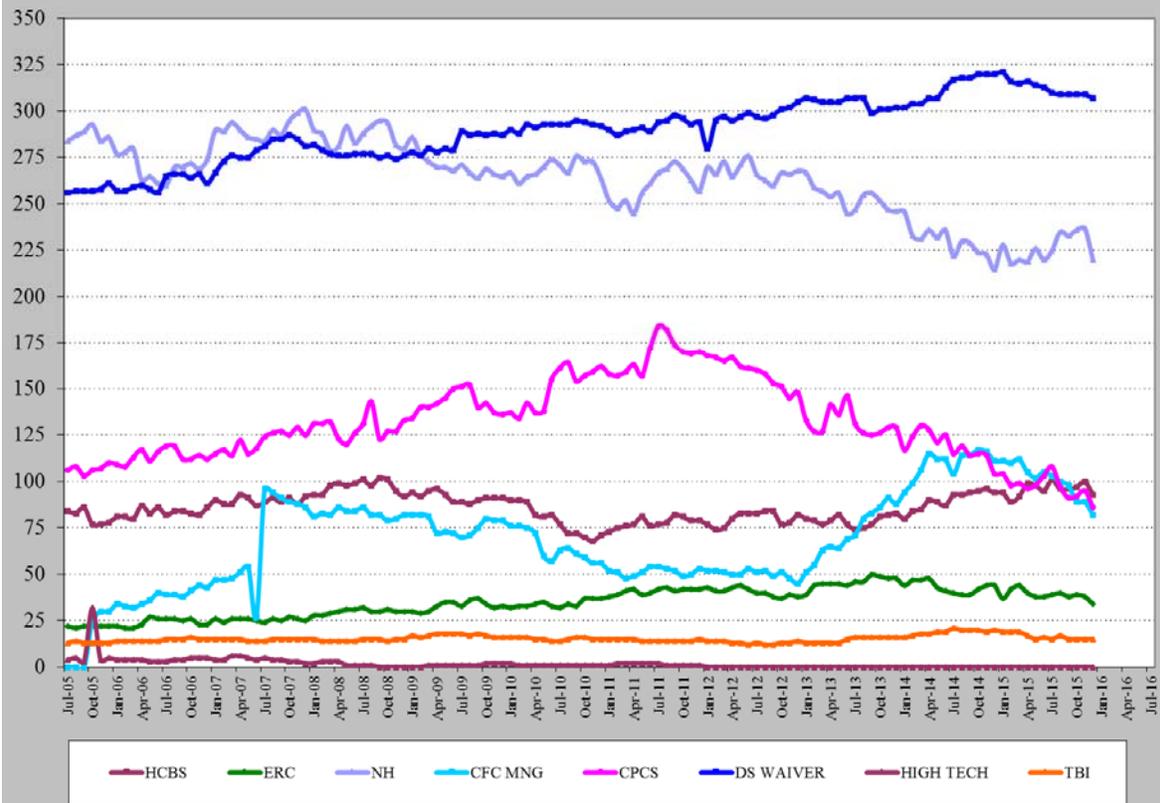
**Numbers of People Receiving Selected Services in Rutland County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



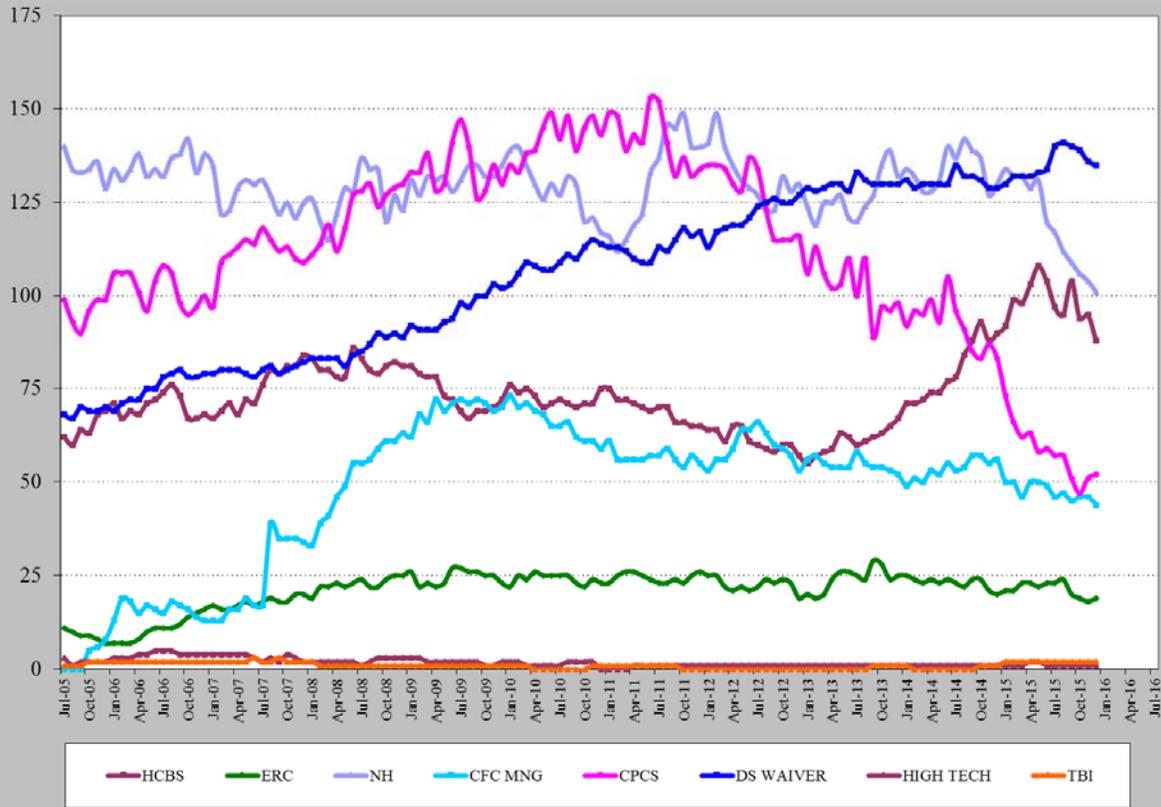
**Numbers of People Receiving Selected Services in Washington County
sfy2005 - sfy2016**

data source: Medicaid paid claims by dates of service



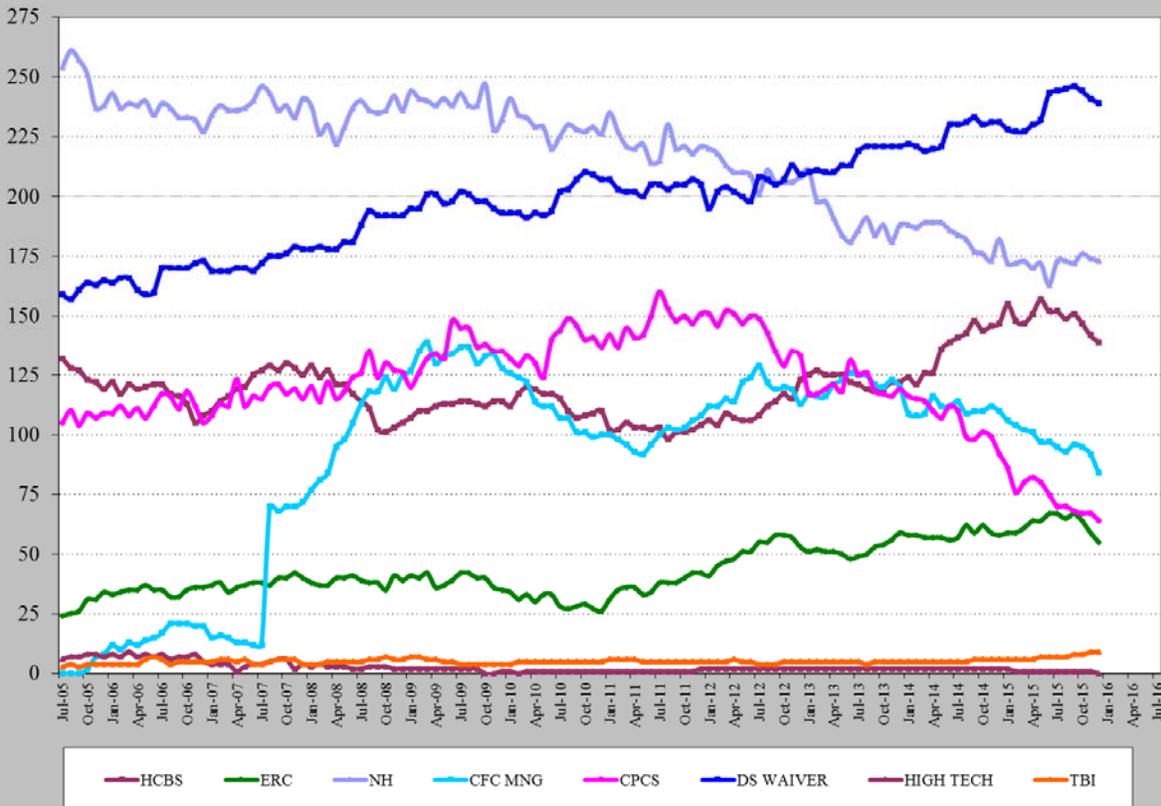
Numbers of People Receiving Selected Services in Windham County
sfy2005 - sfy2016

data source: Medicaid paid claims by dates of service



Numbers of People Receiving Selected Services in Windsor County
sfy2005 - sfy2016

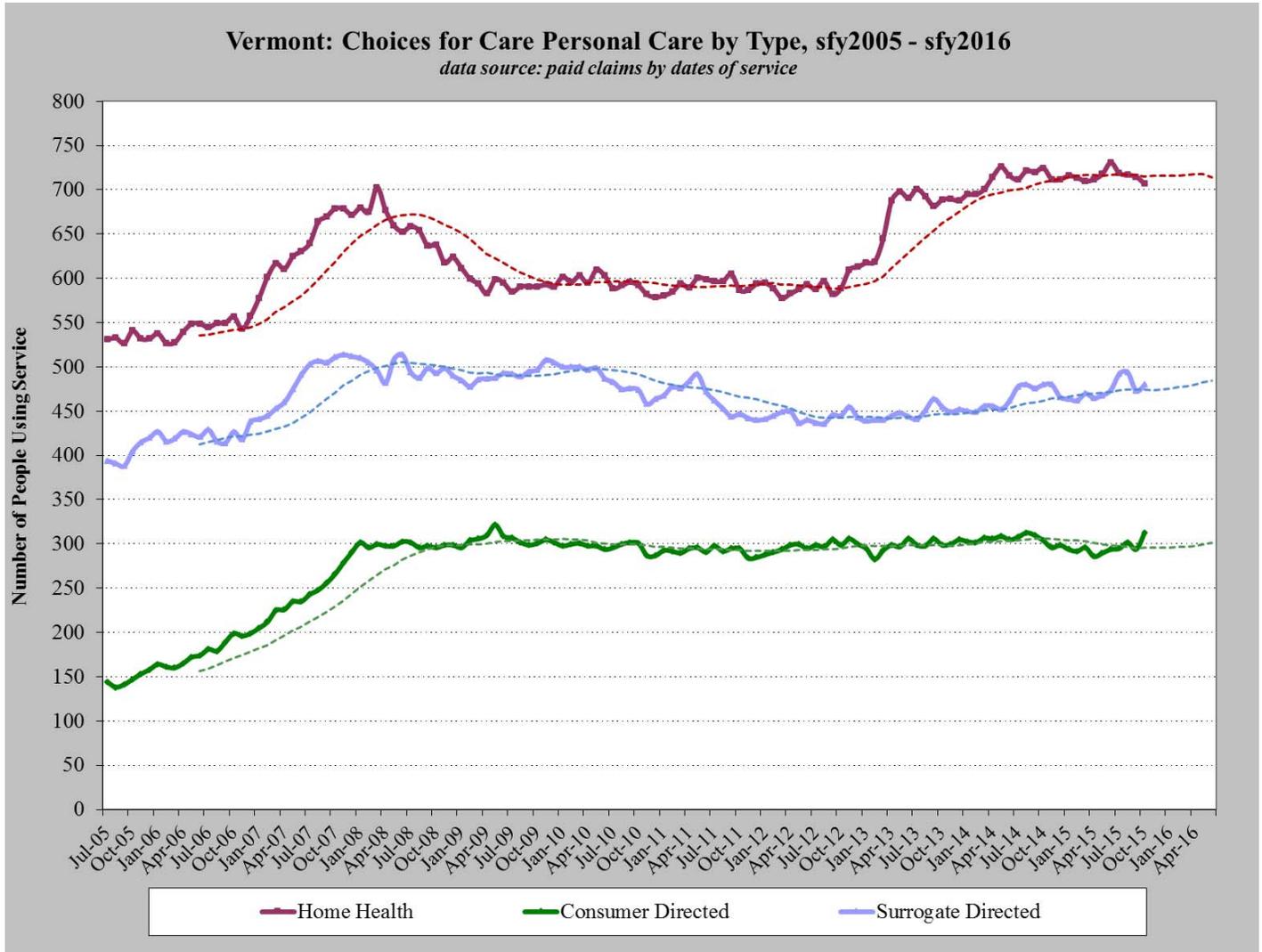
data source: Medicaid paid claims by dates of service



Choices for Care Personal Care Services

The use of Choices for Care personal care services provided by home health agencies has increased in the past two years. Conspicuous increases in Addison, Bennington, and Rutland counties have driven this increase, offsetting decreases in some other counties.

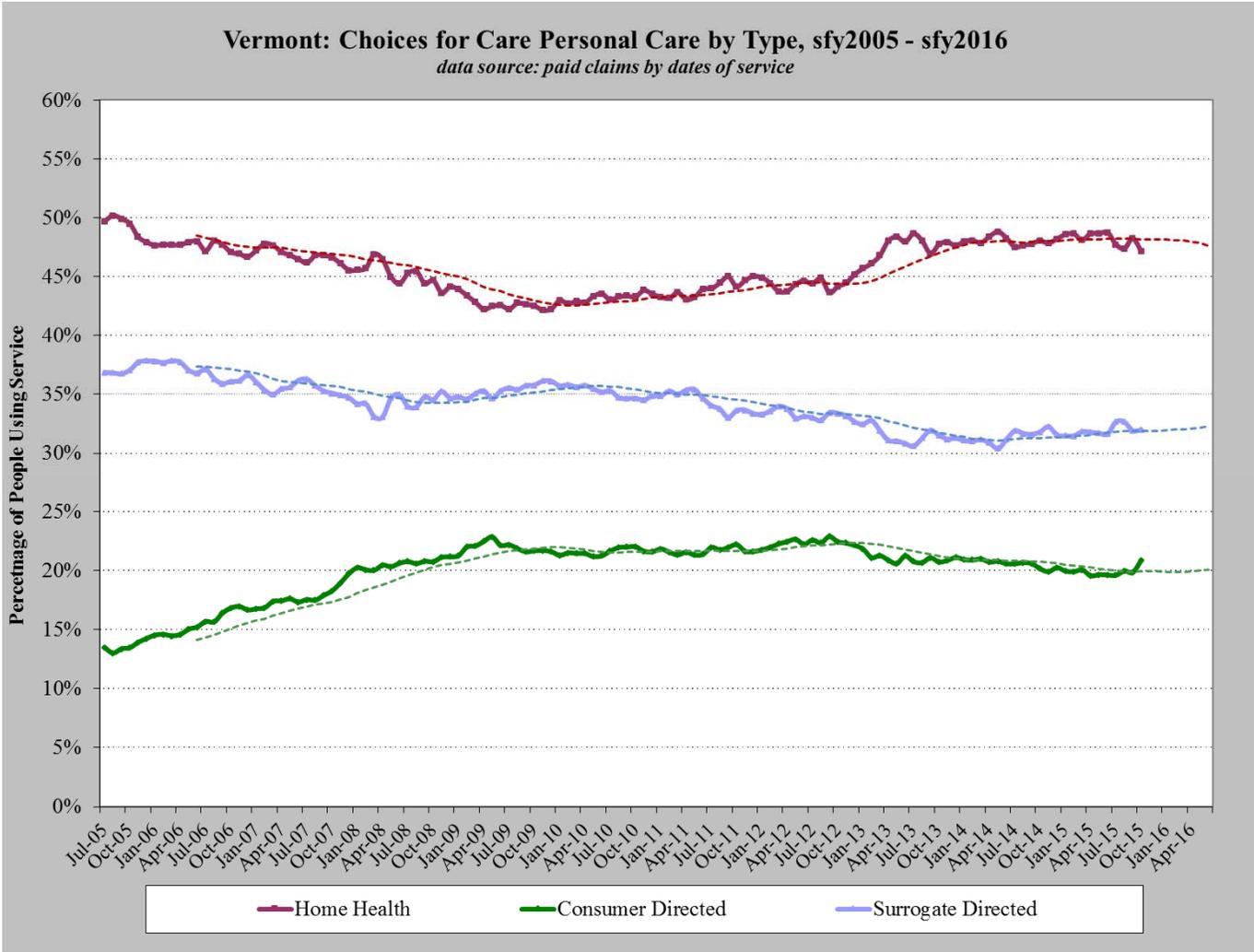
The use of different types of personal care services (home health agency, surrogate directed, or surrogate directed) varies significantly among different Vermont counties, as shown in the following pages.



When Choices for Care began, home health agencies provided half of all personal care services. This share dropped to close to 40% in 2009-2010, but has since increased to close to 50%.

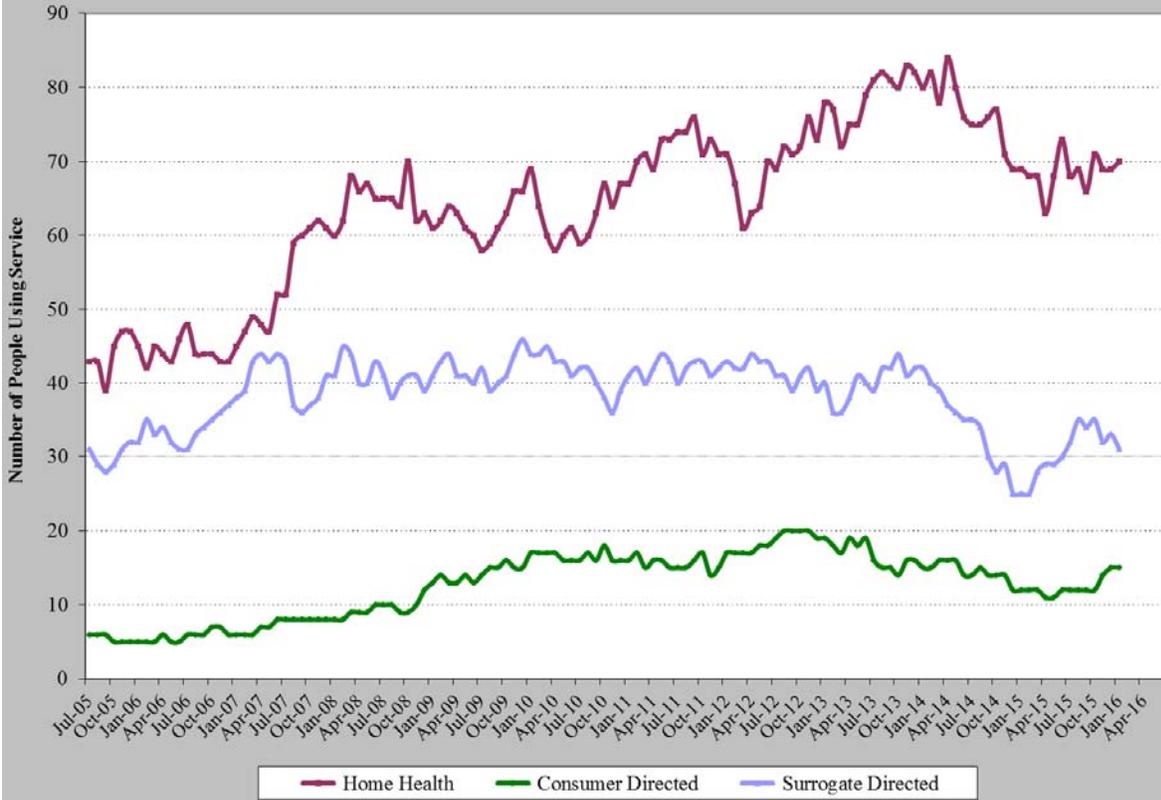
The use of consumer directed personal care services increased from less than 15% to more than 20%. The use of surrogate directed personal care services decreased from more than 35% to close to 30%.

Since 2008, the uses of surrogate directed personal care services and home health personal care services appear to be related, ie an increase in one is associated with a decrease in the other. This suggests some ‘substitution’ of one service for the other when it is unavailable or inadequate, which may be influenced by local home health agency staffing and practices.



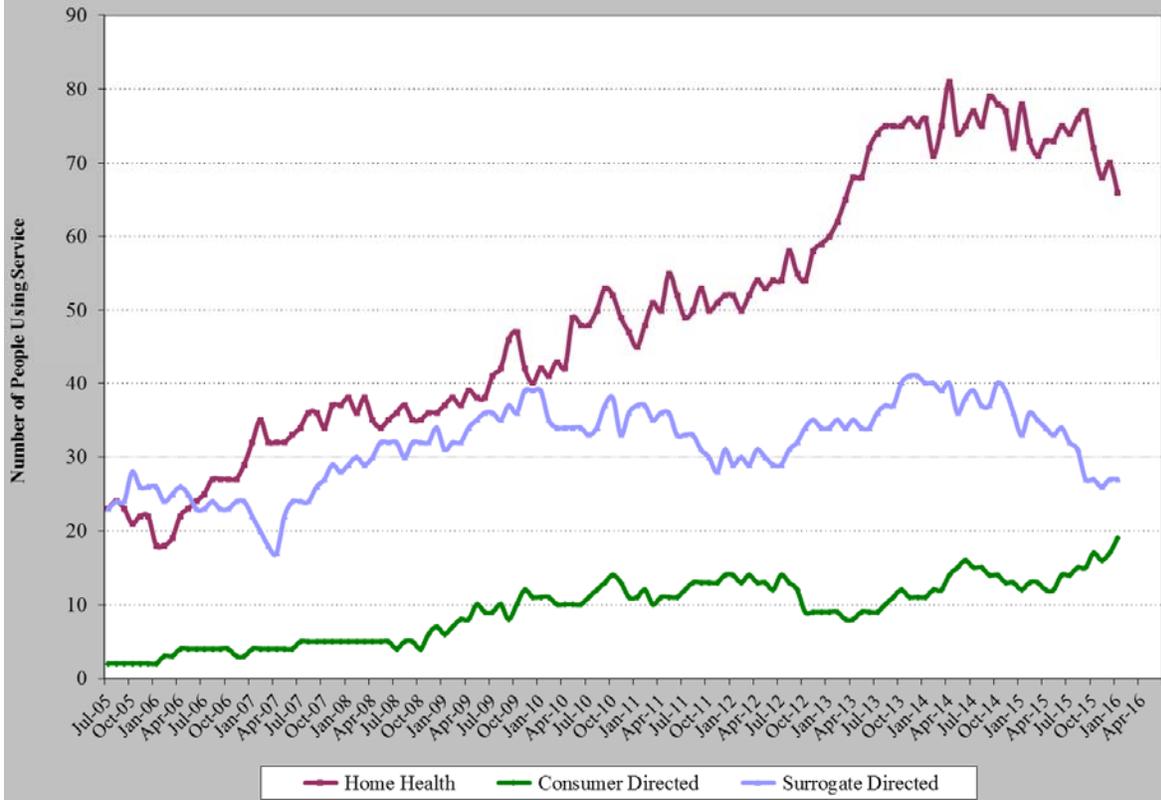
Addison County: Choices for Care Personal Care by Type, sfy2005 - sfy2016

data source: paid claims by dates of service



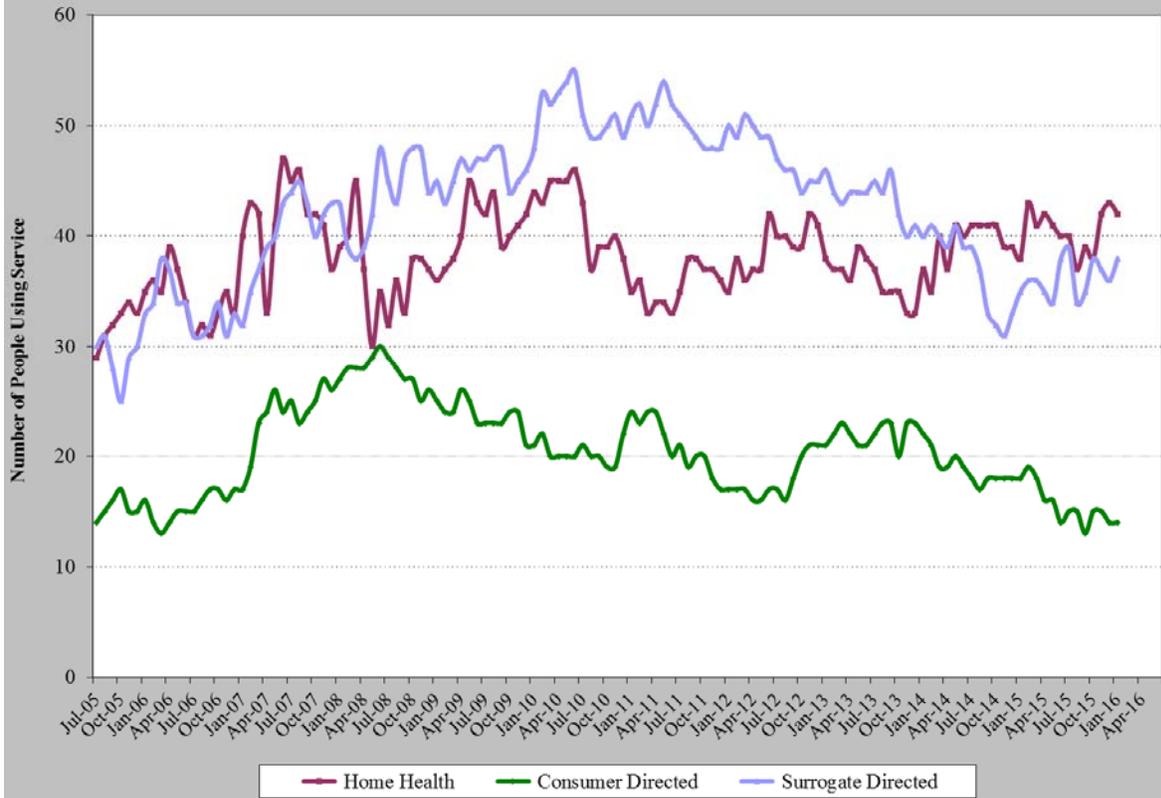
Bennington County: Choices for Care Personal Care by Type, sfy2005 - sfy2016

data source: paid claims by dates of service



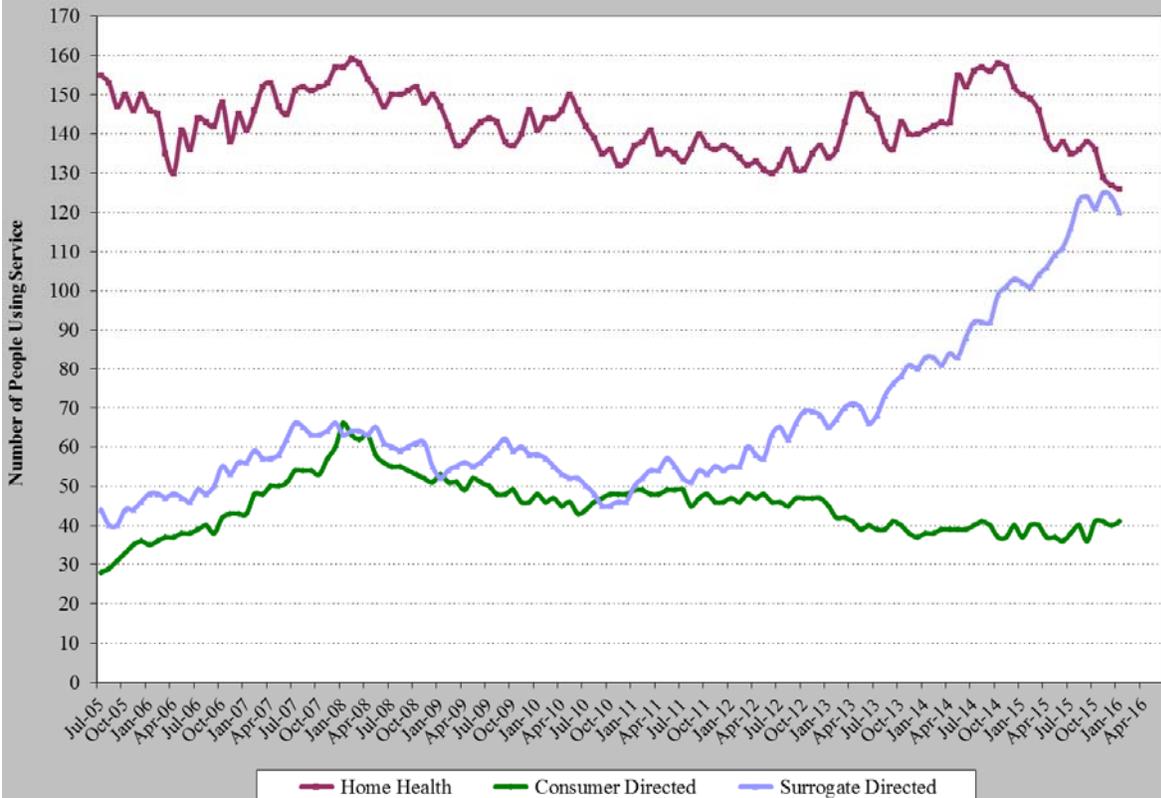
Caledonia County: Choices for Care Personal Care by Type, sfy2005 - sfy2016

data source: paid claims by dates of service

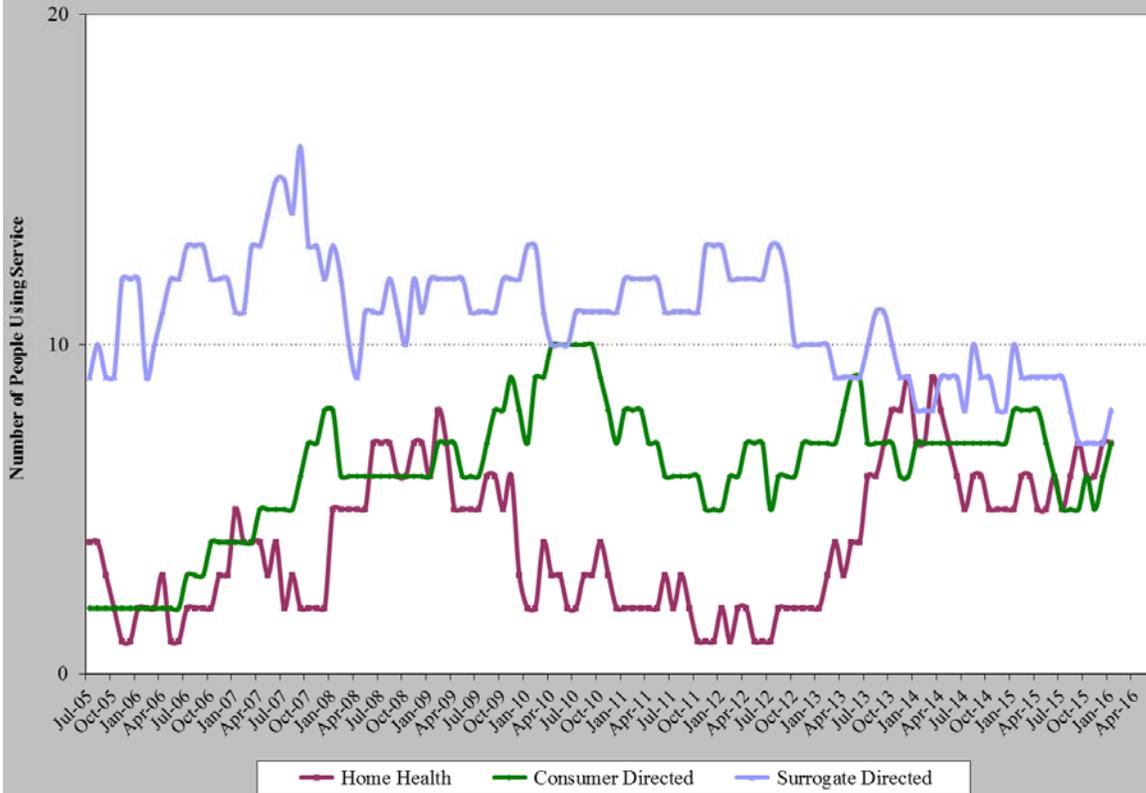


Chittenden County: Choices for Care Personal Care by Type, sfy2005 - sfy2016

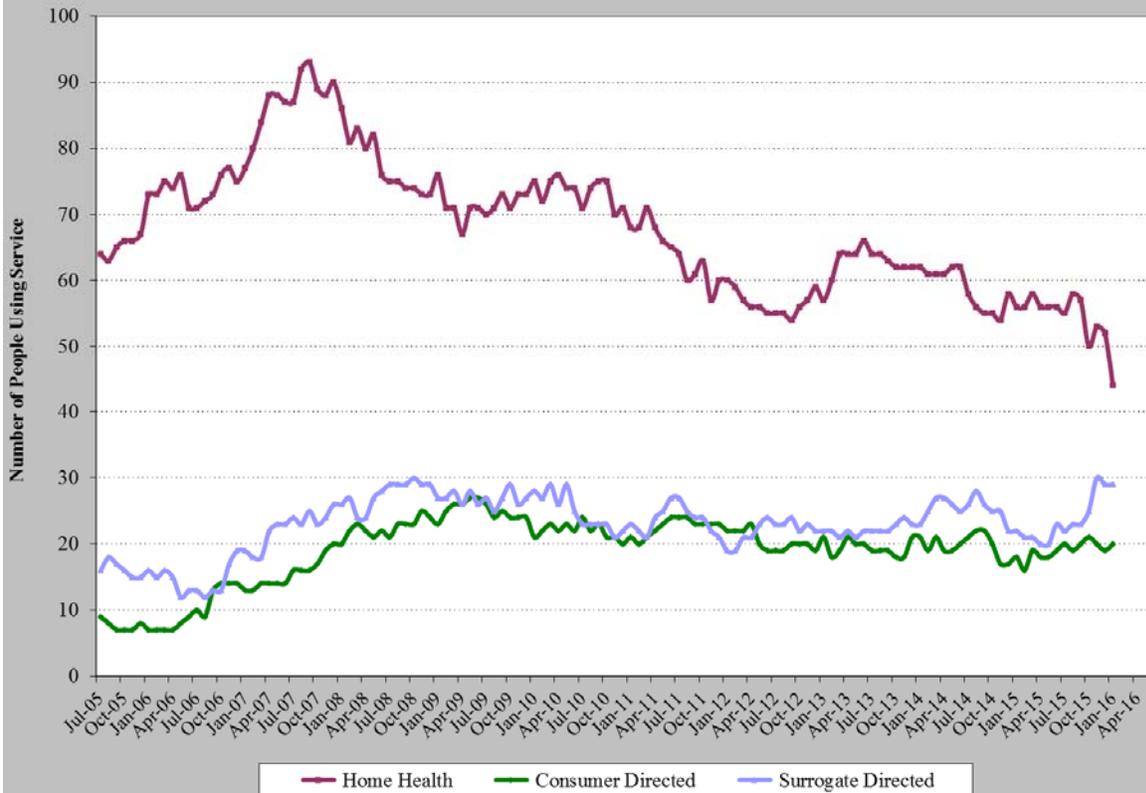
data source: paid claims by dates of service



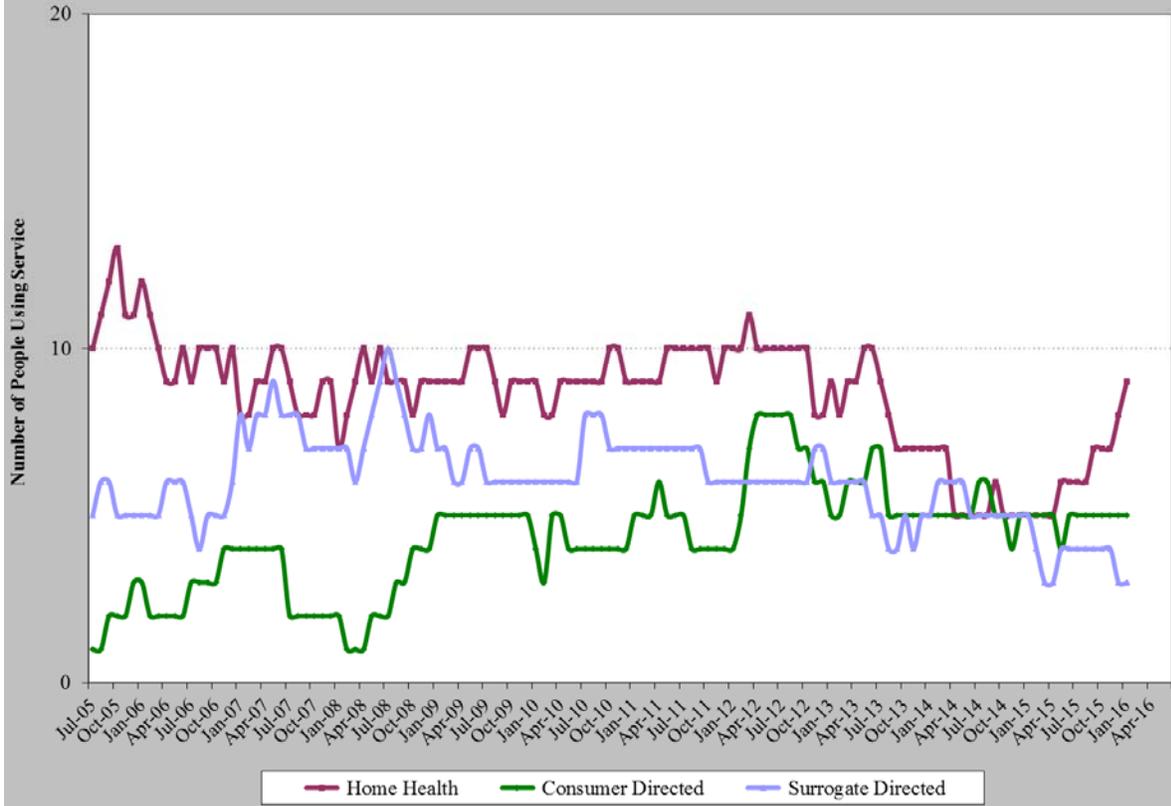
Essex County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service



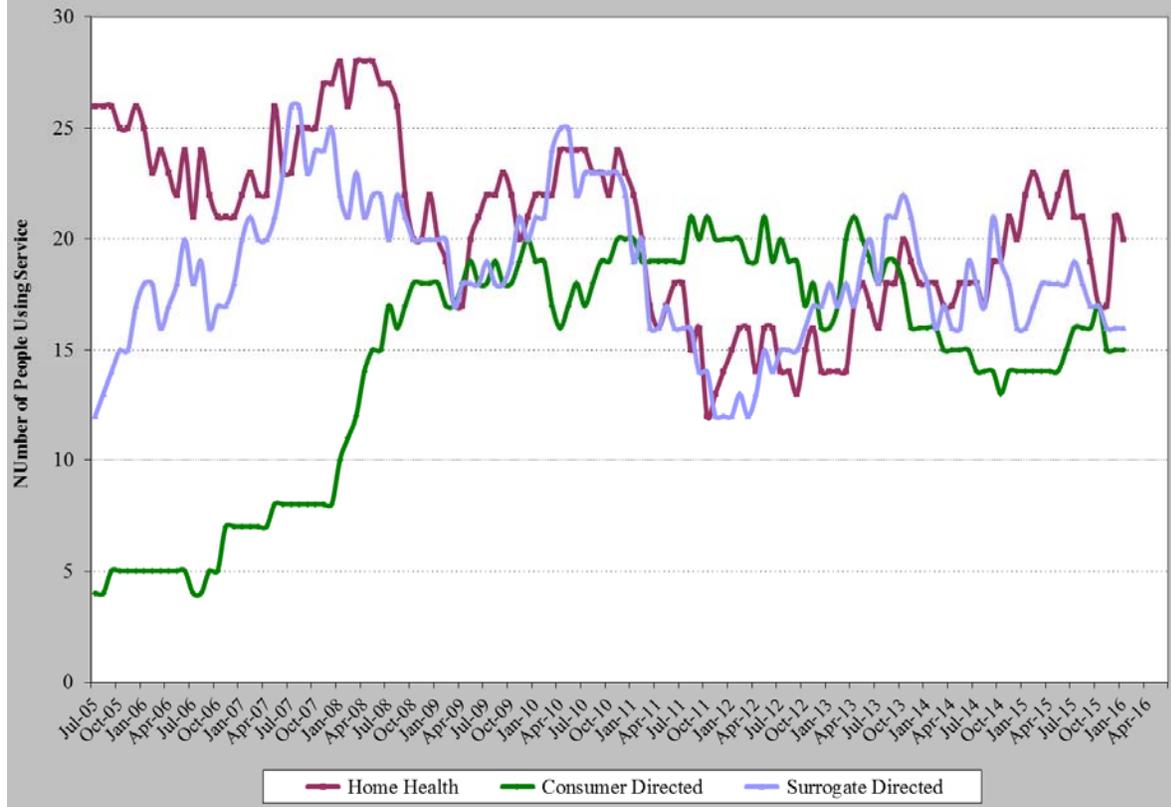
Franklin County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service



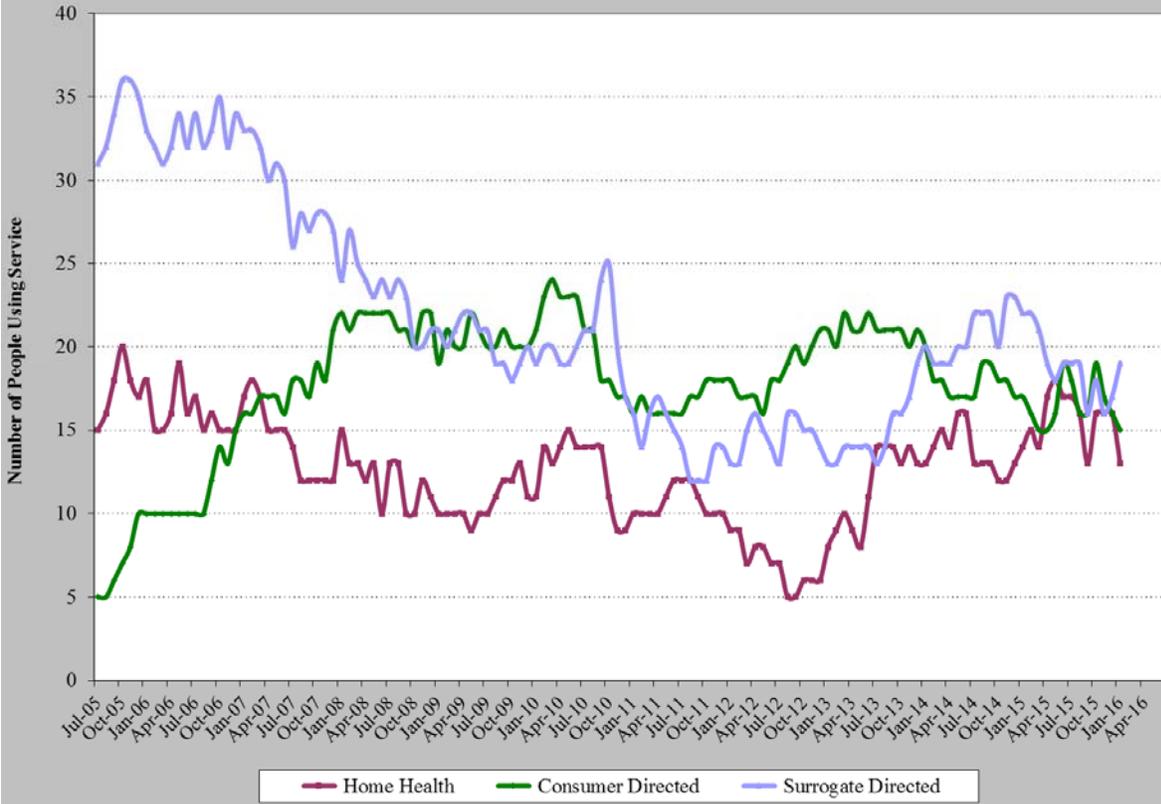
Grand Isle County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service



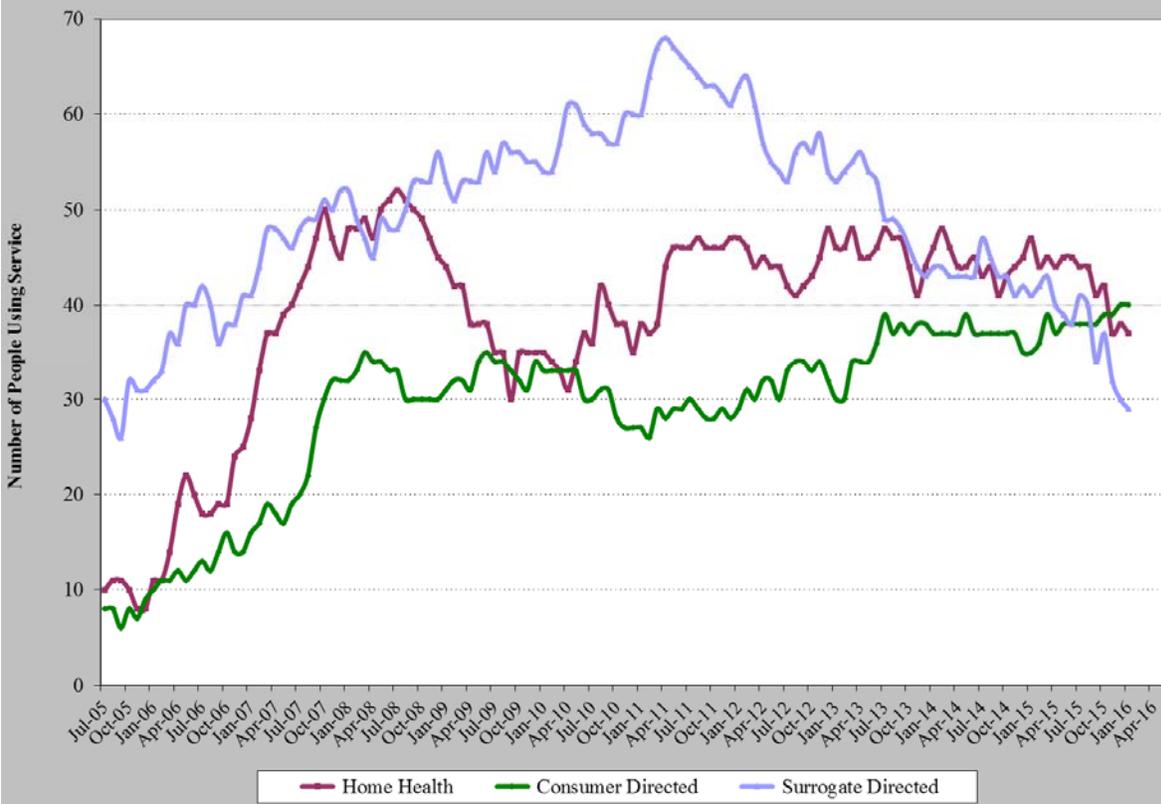
Lamoille County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service



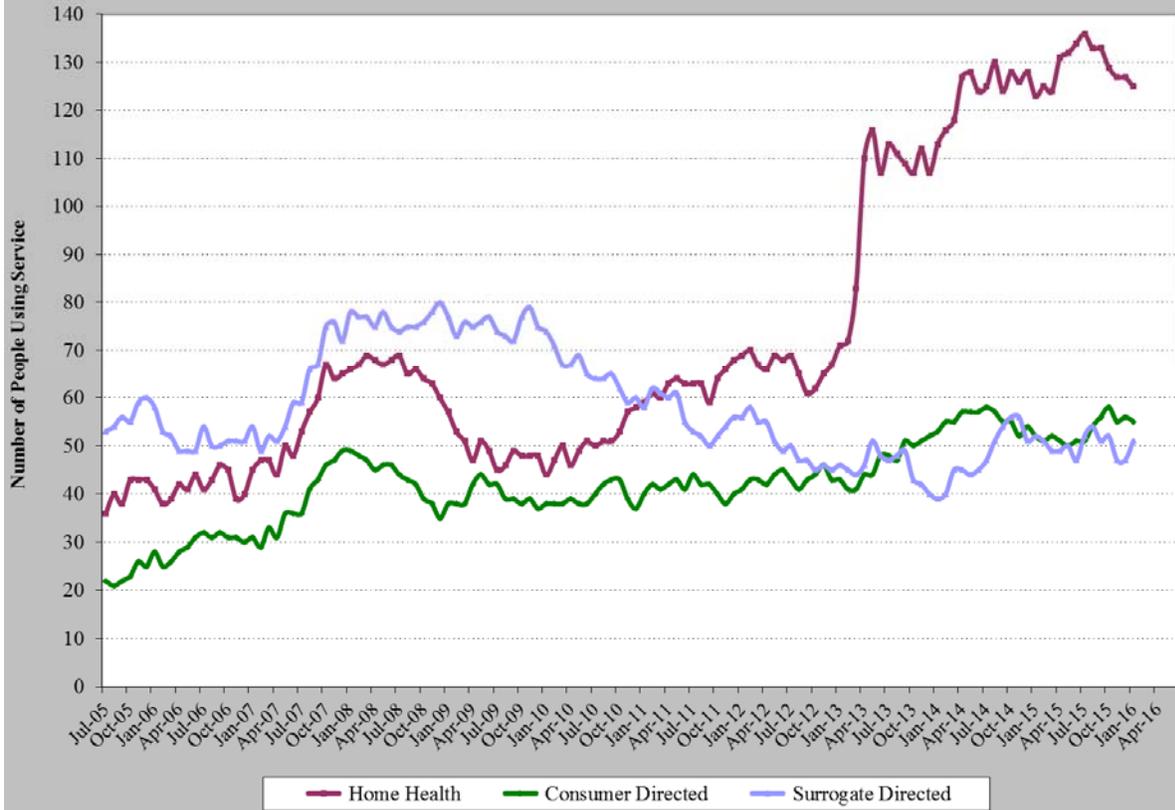
Orange County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service



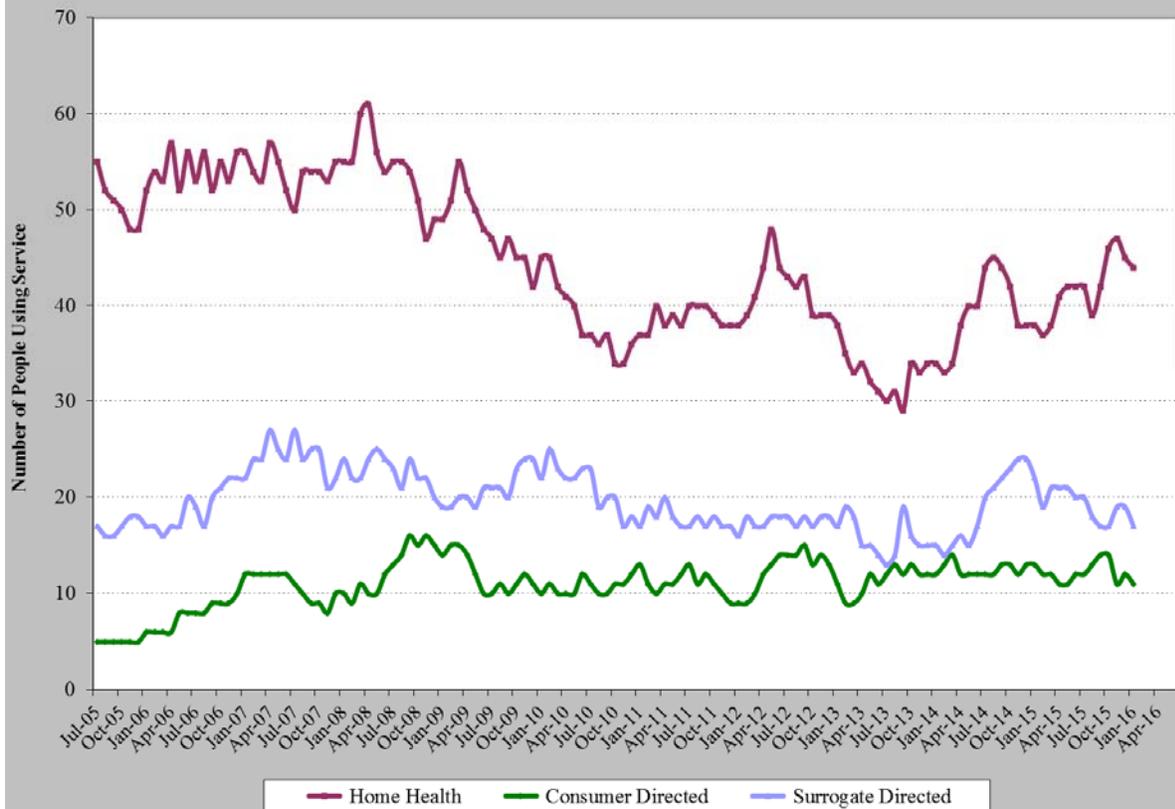
Orleans County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service



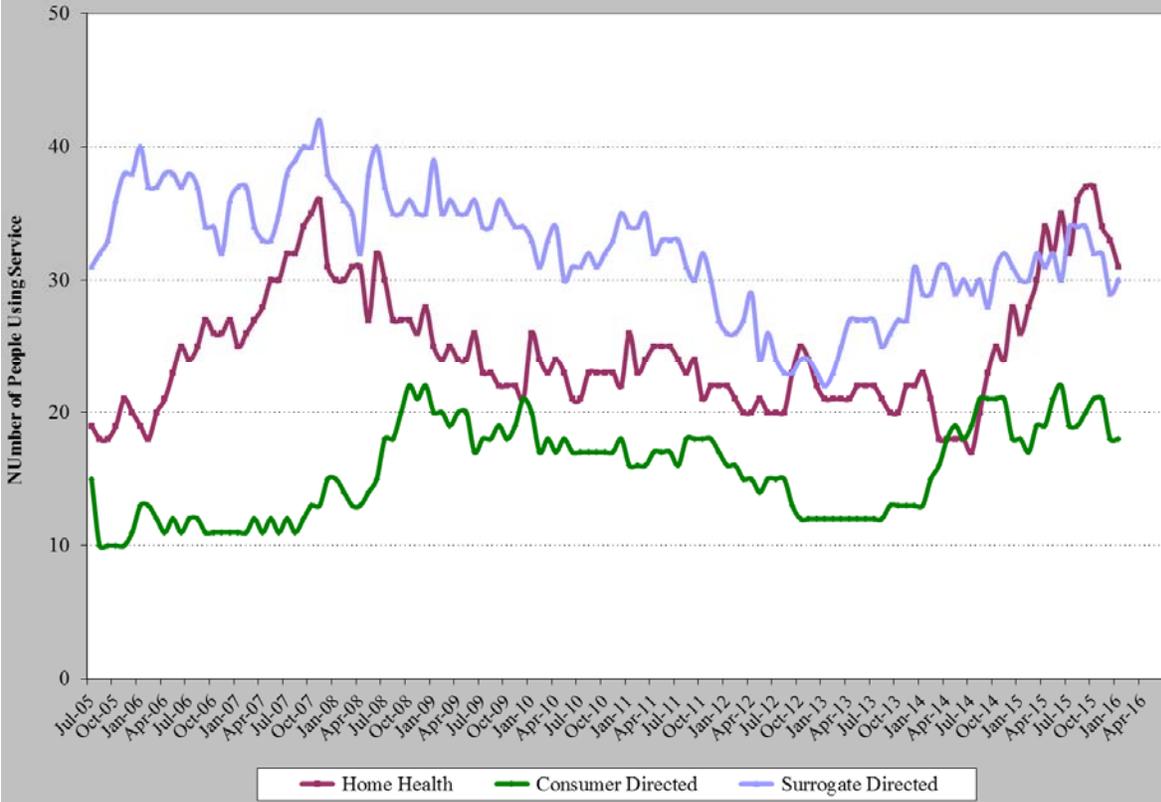
Rutland County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service



Washington County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service



Windham County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service



Windsor County: Choices for Care Personal Care by Type, sfy2005 - sfy2016
data source: paid claims by dates of service

