



Choices for Care

Quarterly Data Report

April 2008

This report describes the status and progress of Choices for Care, Vermont's Medicaid long term care service system. This report is intended to provide useful information regarding enrollment, service, and expenditure trends.

The primary data sources are SAMS Choices for Care enrollment and service authorization data maintained by the Division of Disability and Aging Services, Medicaid claims data maintained by EDS, and resident days of service submitted by Vermont nursing homes to the Division of Rate Setting.

We welcome your comments, questions and suggestions.

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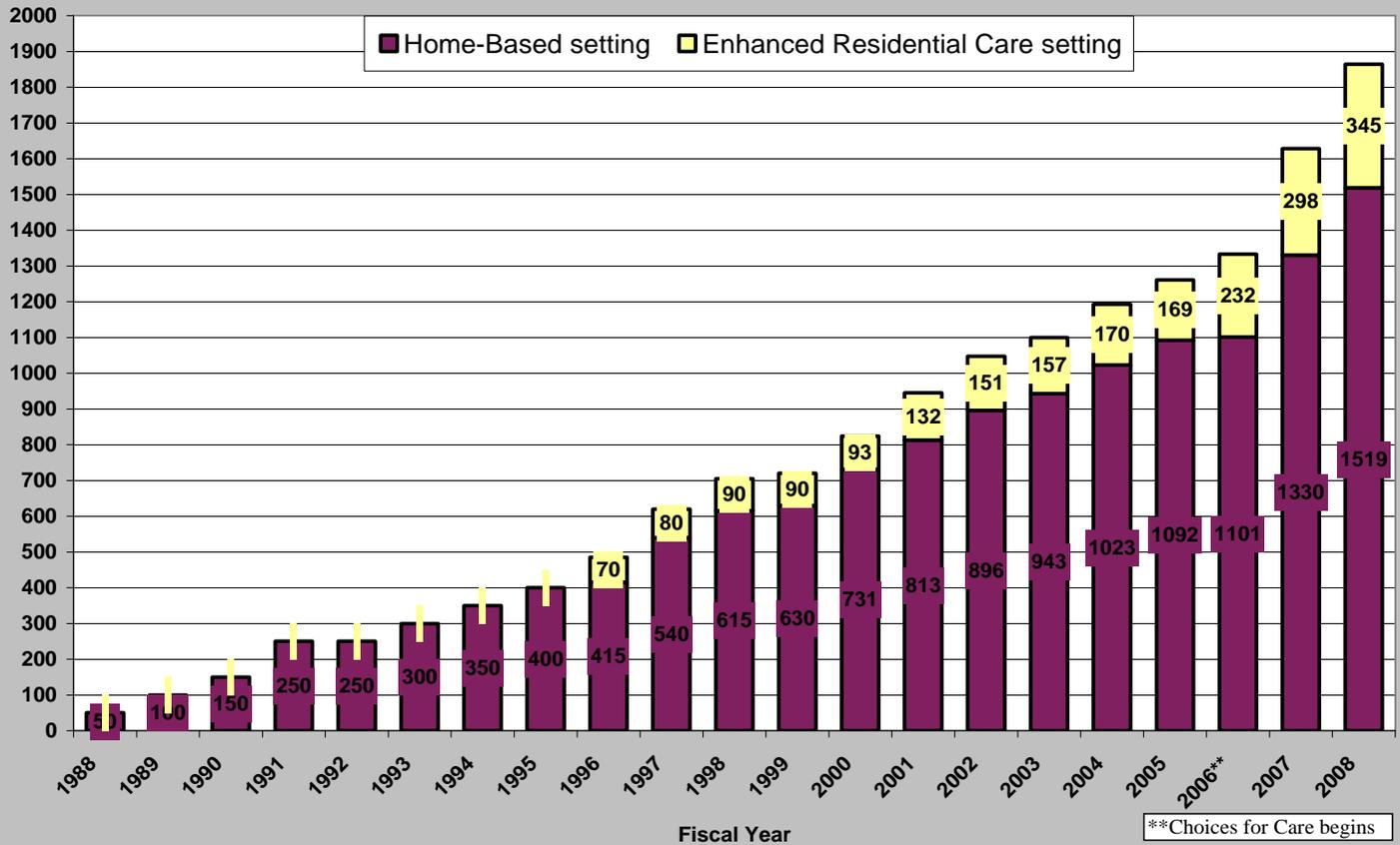
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Numbers of People Served in Aged/Disabled Medicaid Waivers Maximum Number by Year, sfy1988-sfy2008 (ytd, as of 4.08)

(does not include moderate needs group)



Data source: DAIL/DDAS databases

* years preceding Choices for Care, with limited funding and enrollment

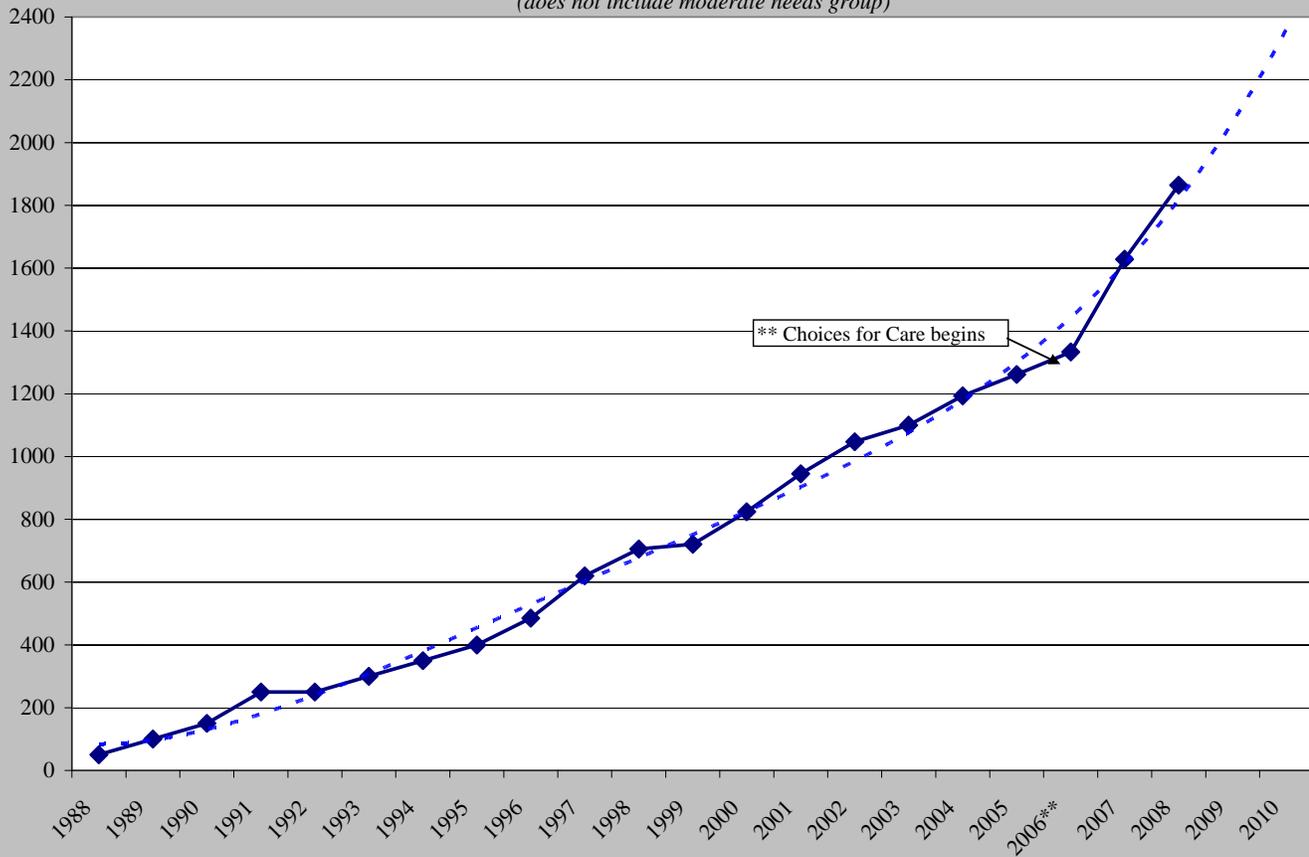
This graph illustrates the growth in home and community based services in Vermont since sfy1988.

Prior to the implementation of Choices for Care in October 2005, growth was fairly steady, but limited by the funding available within each fiscal year. During these years eligible Vermonters were entitled to receive nursing home care under Medicaid, but were not entitled to receive home and community-based long term care services as an alternative. Some people were placed on waiting lists until funding for home and community based services became available.

In the first three quarters of sfy2008, the number of people enrolled in home and community-based settings increased by more than 225, following an increase of more than 300 in sfy2007. This increase in the number of people served is significantly higher than before Choices for Care, representing annual increases of approximately 20%.

Numbers of People Served in Aging/Disabled Medicaid Waivers Maximum Number Served by Year, sfy1988-sfy2008 (ytd)

(does not include moderate needs group)

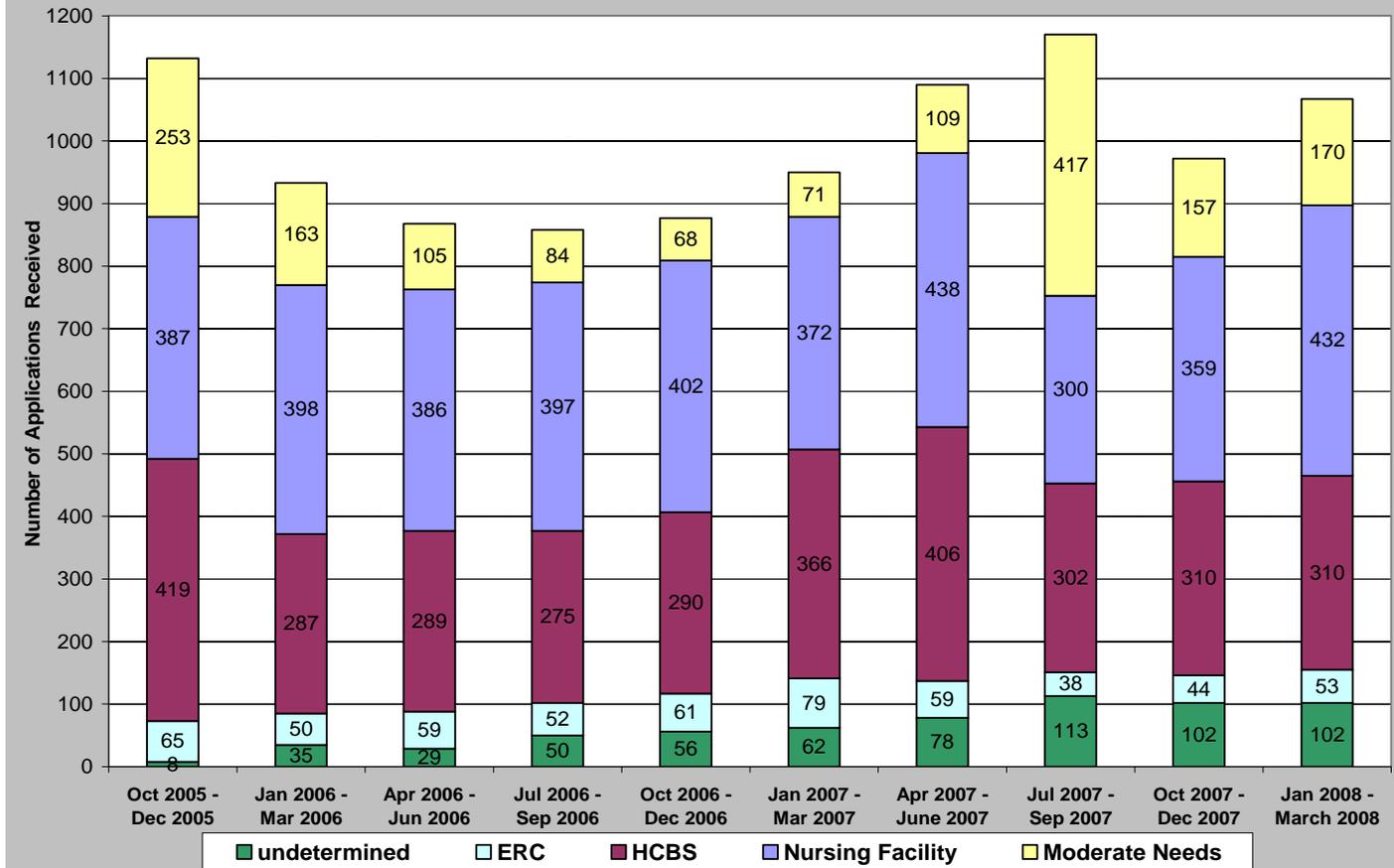


Data source: DAIL/DDAS databases

This graph combines HCBS and ERC enrollment data, and projects the historical enrollment trend through sfy2011.

Note the steep growth following the implementation of Choices for Care in sfy2006. The trend line suggests that enrollment in these alternative settings will continue to increase.

**Choices for Care: Applications Received by Service Program
October 2005 through March 2008**



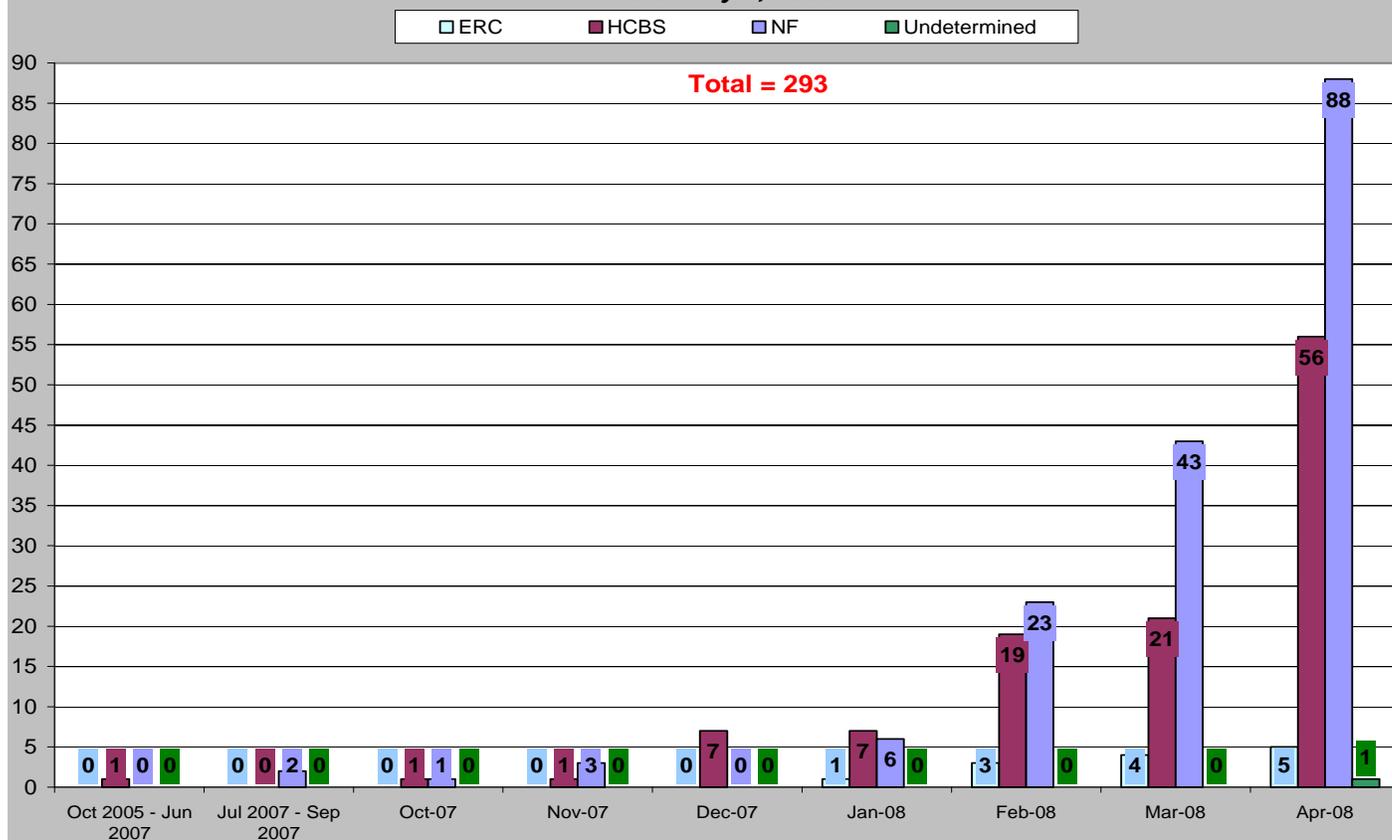
Data source: DAIL/DDAS SAMS database.

This shows the number of applications received over time. Since October 2005, DAIL staff processed an average of about 325 applications per month.

Highlights:

1. The percentage of people who applied for each service setting:
 - NF: 36%
 - HCBS: 31%
 - MNG: 19%
 - ERC: 7%
2. The number of applications has increased since December 2006. In CY2006, DAIL staff received about 3500 applications. In CY2007, DAIL staff received about 4200 applications. In the first quarter of CY2008, DAIL staff received more than 1050 applications.

**Choices for Care: Applications 'Pending Medicaid' by Status Date
October 2005 through April 2008
as of May 1, 2008**



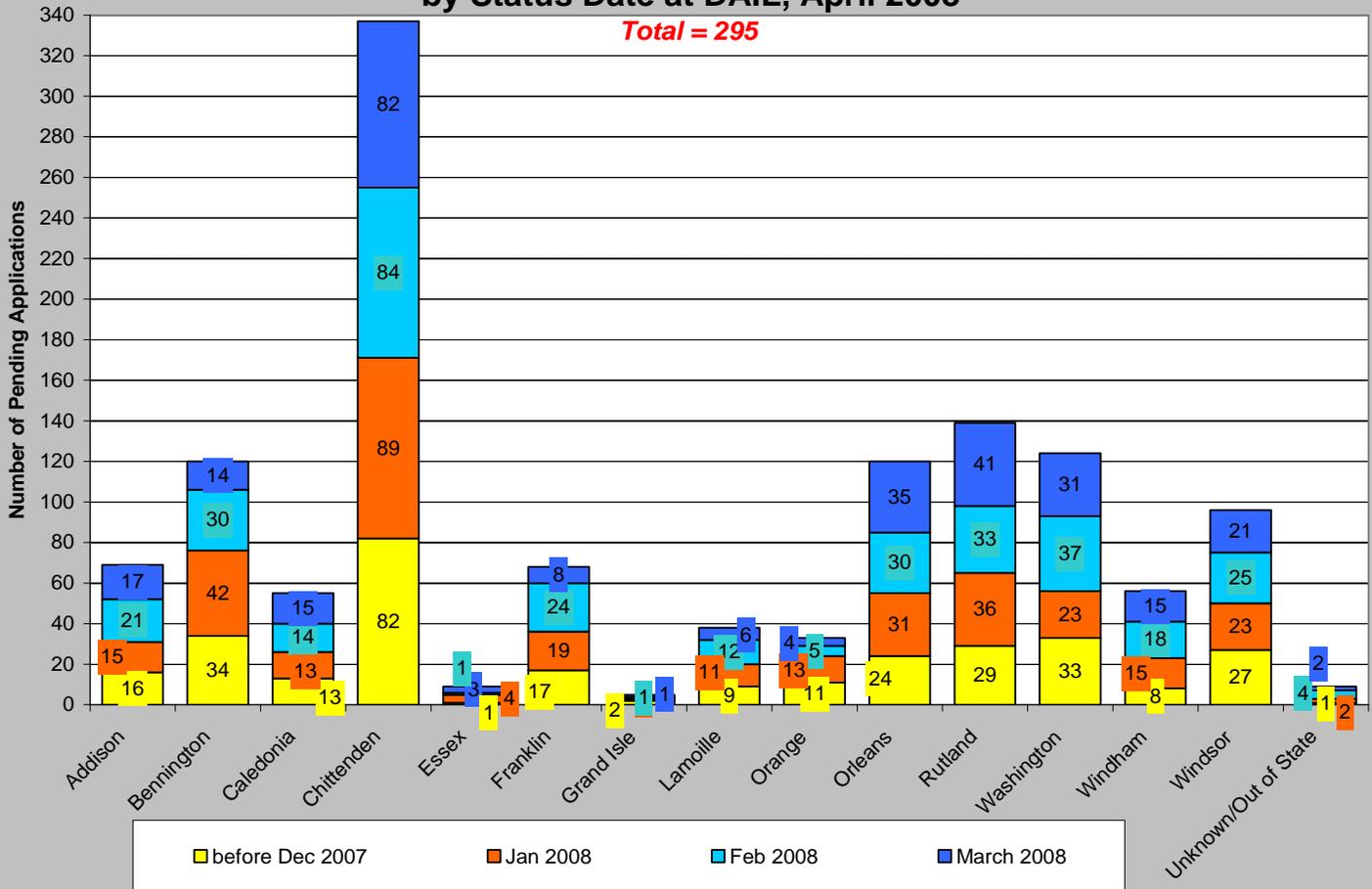
Data source: DAIL/DDAS SAMS database.

One of the goals of Choices for Care is to help Vermonters access long term care services when they need them. One indicator of success in achieving this goal is the time required to process individual applications. The number of pending applications was over 400 for a number of months; the number has decreased to less than 300. Ongoing communication and collaboration between DAIL regional staff, DCF regional staff, and local case managers contributes to the timely processing of applications.

Most applications are processed within eight weeks. Over 90% are processed within twelve weeks. A small percentage remains pending for many months due to delays in Medicaid eligibility. Causes of delays in Medicaid eligibility determination include:

1. Long-term care Medicaid applications are not submitted.
2. Long-term care Medicaid applications are delayed or incomplete.
3. Some applicants must spend or otherwise dispose of their excess resources.
4. Some applicants under the age of 60 (those not already eligible for SSI) are required to undergo a Disability Determination process, which routinely requires several months.
5. Some applications lead to complicated asset searches and/or legal review by the Department for Children and Families (DCF).

Choices for Care: Pending Medicaid Applications by County by Status Date at DAIL, April 2008



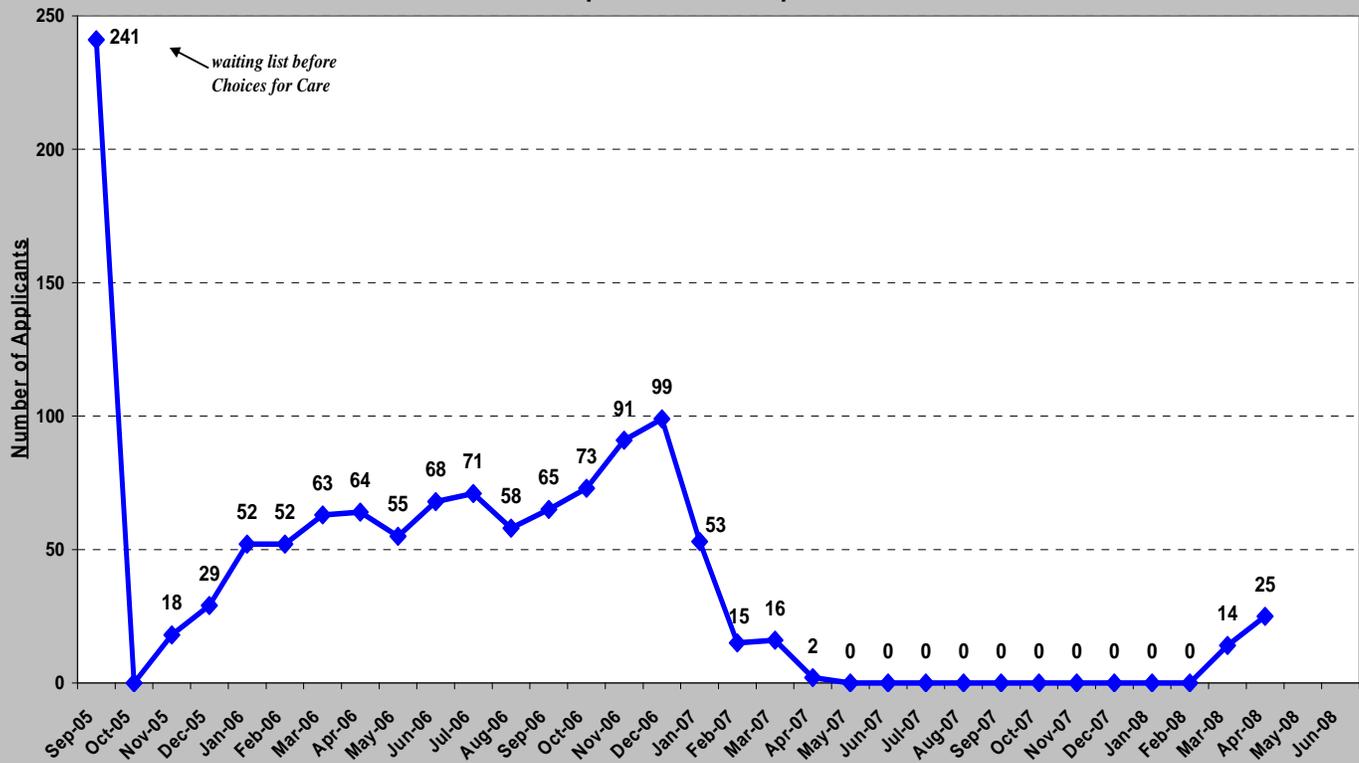
Data source: DAIL/DDAS SAMS database.

This graph provides a measure of DAIL and DCF workload and performance within each county. Bennington, Grand Isle, Orange, Washington and Windsor counties have relatively high percentages of applications that had been received more than 90 days ago.

The number of “old” pending applications can be used as an indicator of success in ensuring timely access to services. About half of all pending applications had been received within the last two months:

Received	Number	Percent
< 31 days	295	23%
31-60 days	339	26%
61-90 days	337	26%
> 90 days	307	24%

Choices for Care High Needs Waiting List, by Month
September 2005 - April 2008



Data source: DAIL/DDAS SAMS database.

A primary goal of Choices for Care is to improve access to home and community based services; one measure of this is the number of people on waiting lists. Waiting lists for home and community-based services are common across the United States. In some states, the number of people on waiting lists is unknown. In other states, waiting lists are long and getting longer:

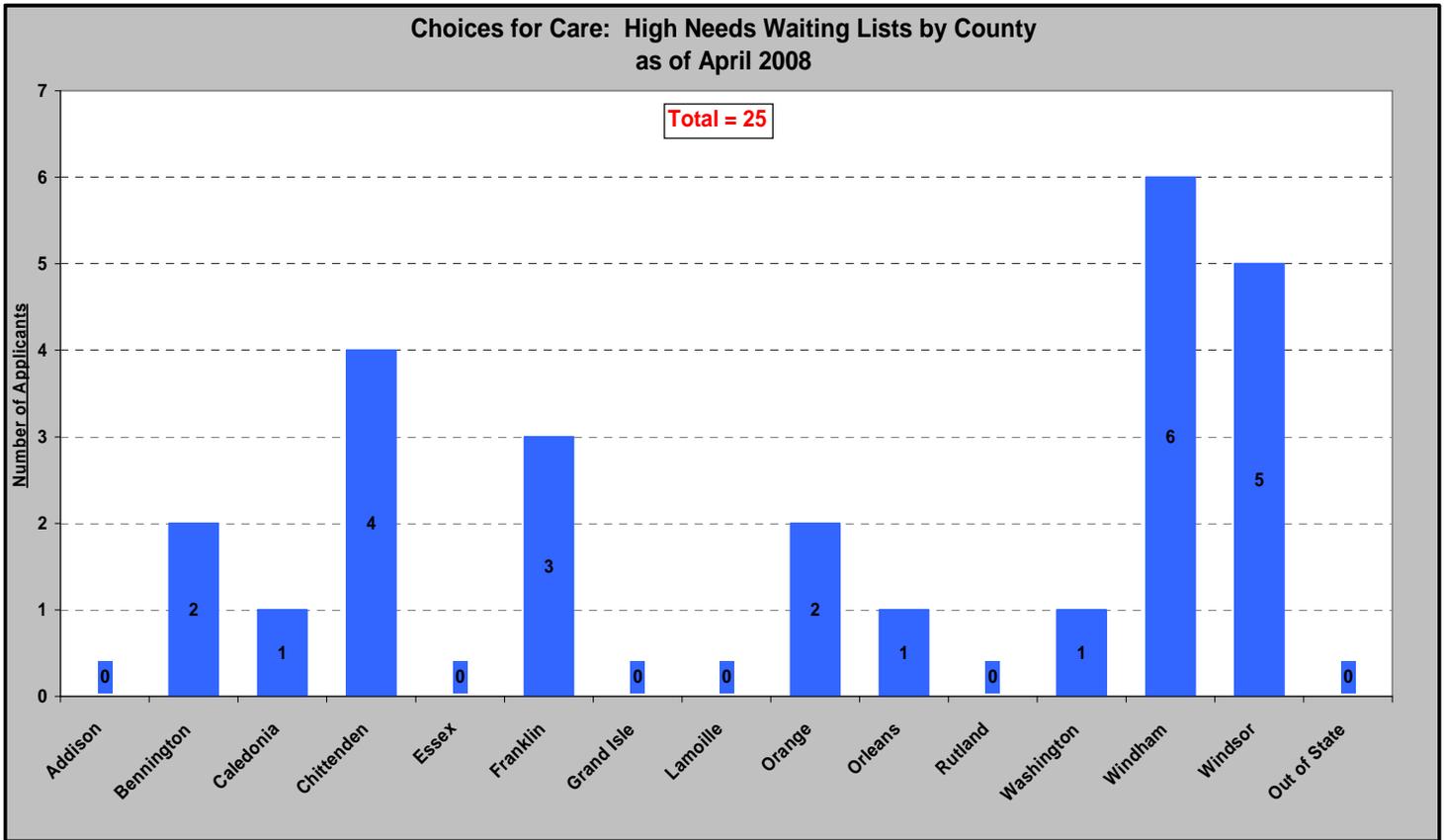
In 2005, 260,916 individuals were on waiting lists for 102 waivers in 30 states, up from 206,427 individuals in 2004. The average length of time an individual spends on a waiting list ranges from 13 months for aged/disabled waivers to 26 months for MR/DD waivers. Kaiser Commission on Medicaid and the Uninsured, Medicaid 1915(c) Home and Community-Based Service Programs: Data Update, December 2006

Prior to Choices for Care, Vermonters were commonly placed on waiting lists. The total number of people on waiting lists fell when Choices for Care was implemented in October 2005, when those applicants who met the Highest Needs Group eligibility criteria became entitled to services.

The High Needs Group was created as a financial ‘safety valve’ in the Choices for Care expanded entitlement to HCBS. Due to concerns about enrollment and expenditure patterns, in October 2005 all applicants who met the High Needs Group eligibility criteria were placed on a waiting list. The number of people on this waiting list slowly increased over time. Based on the availability of funds, small numbers of people from the waiting list were enrolled in Choices for Care during July 2006 and December 2006. In January 2007, Choices for Care expenditure patterns allowed all High Needs Group applicants to

be enrolled, and the waiting list fell to zero. Due to recurring financial pressures, the high needs group waiting list was resurrected in February 2008.

Of the 25 people on the waiting list in April 2008, 22 people were waiting for services in the HCBS setting (including one waiting for PACE) and 3 people were waiting for services in the NF setting.

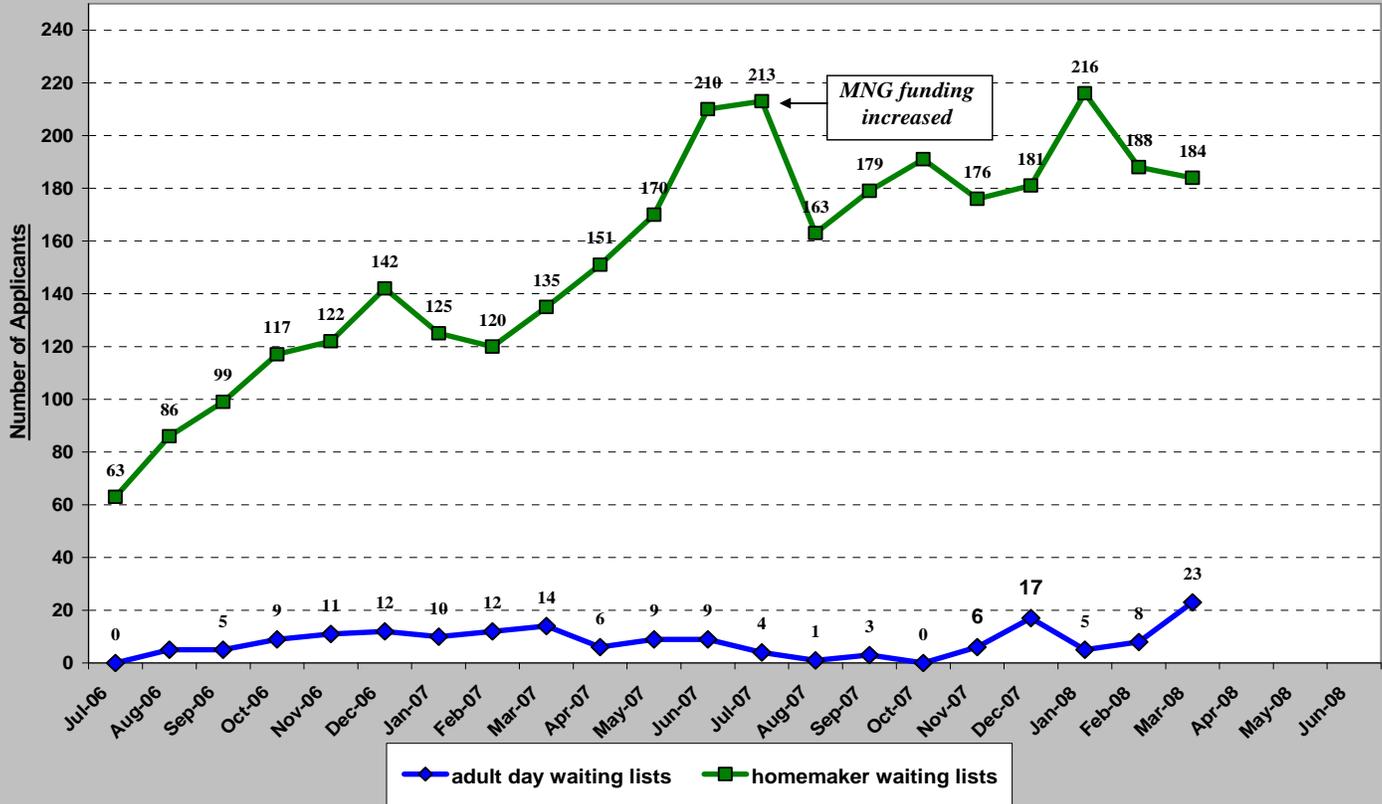


Data source: DAIL/DDAS SAMS database.

This graph shows the distribution of the High Needs Group waiting list by county. The waiting lists in Windham and Windsor counties are disproportionately large.

Choices for Care regulations allow people who meet High Needs Group eligibility criteria to be enrolled under ‘special circumstances’ to receive services. Since February 1 2008, a total of 27 people have been found clinically eligible under ‘special circumstances’. This includes 21 people approved for the NF setting, 4 people approved for the HCBS setting, and 2 people approved for the ERC setting. Within the 21 people approved for the NF setting, 5 people were found eligible because no ‘alternative placement’ to a nursing home was available, and 7 people were approved for short-term rehabilitation.

Choices for Care: Moderate Needs Group Waiting Lists by Type of Service SFY2006 - SFY 2008



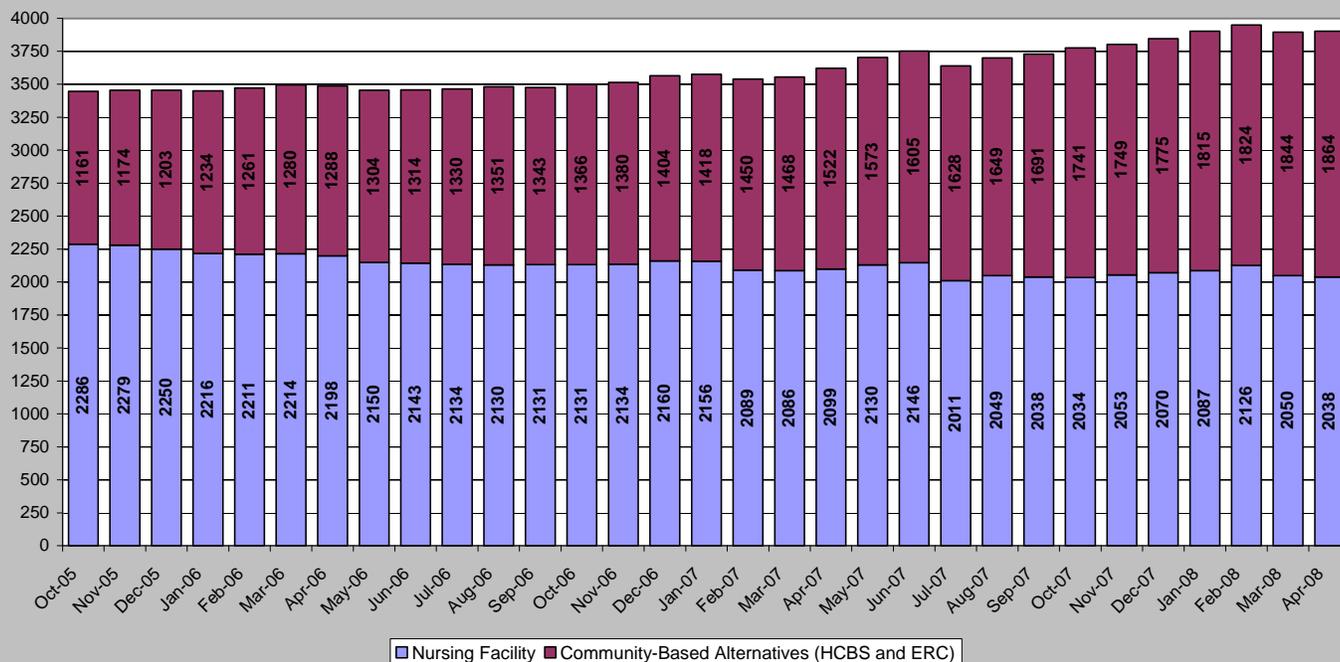
Data source: waiting list reports from home health agencies and adult day programs.

This graph shows the numbers of people placed on waiting lists for Moderate Needs Group services. The graph starts in July 2006, when providers began to submit monthly waiting list data to DAIL/DDAS. The number of people waiting for Homemaker services has remained substantially higher than the number of people waiting for Adult Day services.

Of the thirteen Homemaker providers, four reported waiting lists in March 2008. The number of people on these waiting lists ranged from 13 to 106. Note that Homemaker waiting lists continued after a substantial increase in funding in July 2007, and that current service projections show that funds will remain unused at the end of the fiscal year. This suggests that all Homemaker waiting lists are not caused by limited funding. Some providers have reported that the costs of providing services are higher than the reimbursement rate, and limit the number of hours of service that they provide. Some providers have also reported challenges in recruiting and retaining adequate numbers of staff.

Of the fourteen Adult Day providers, three reported waiting lists in March 2008. The number of people on these waiting lists ranged from 4 to 15.

Choices for Care: Total Number of Enrolled Participants
October 2005 - April 2008
(highest and high needs group only - excludes moderate needs group)



Data source: DAIL/DDAS SAMS database.

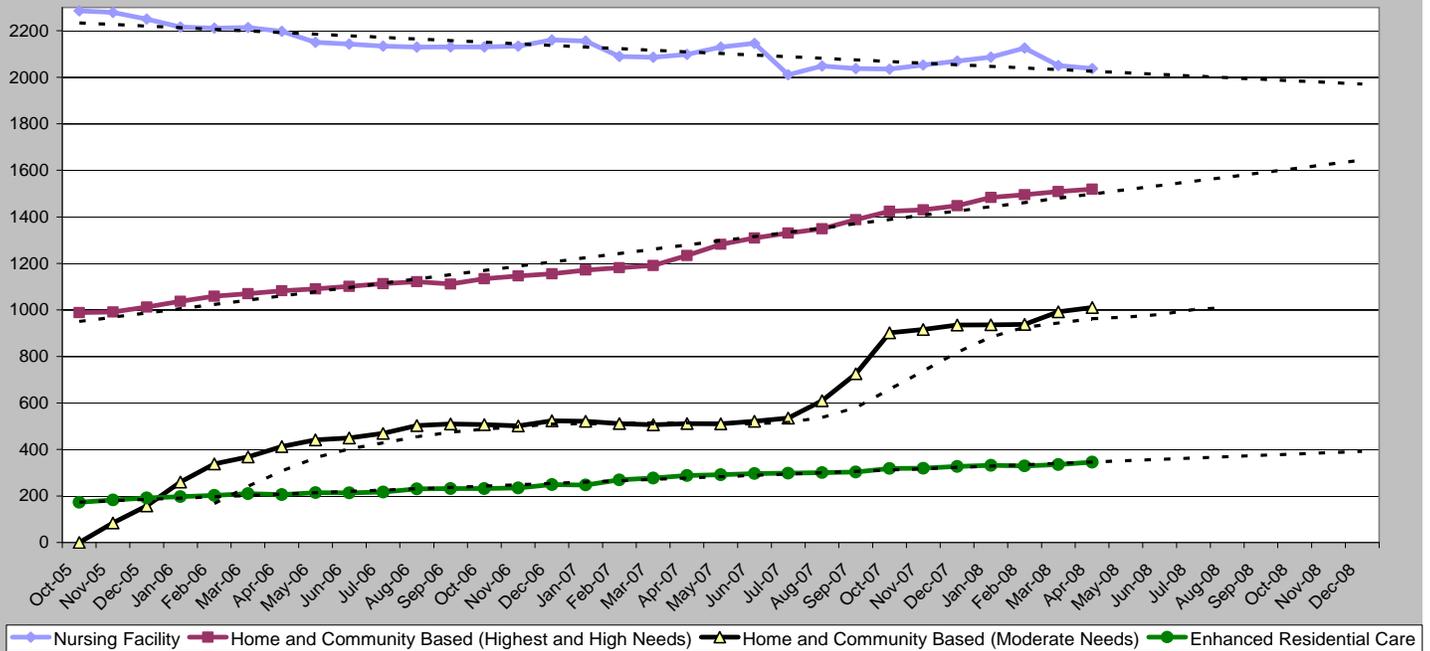
This graph shows trends in enrollment of people in the Highest Needs Group and the High Needs Group. All of these people met the ‘traditional’ nursing home clinical and functional eligibility criteria that existed before Choices for Care.

The number of people enrolled in these two eligibility groups has grown significantly. In two and a half years, the total number enrolled has increased by more than 450 people (about 13%). This includes a decrease of about 250 people in nursing homes, and an increase of about 700 people in home and community-based settings.

Prior to Choices for Care, the number of people enrolled in HCBS and ERC settings increased by about 100 per year. During Choices for Care, the number of people enrolled in HCBS and ERC settings has increased by about 280 per year, while the number of people enrolled in the NF setting has decreased by about 100 per year.

These enrollment and associated expenditure patterns are sustainable in the short term. It is not yet clear if the enrollment trends support or refute initial concerns about a ‘woodwork effect’, in which people enroll in Medicaid HCBS long term care services without reducing nursing home use and expenditures. This could cause increases in expenditures that are not sustainable in the long term.

**Choices for Care: Total Number of Enrolled Participants
October 2005 - April 2008**



Data source: DAIL/DDAS SAMS database.

This graph shows the monthly changes in enrollment in Choices for Care since October 2005.

Nursing homes: the number of people enrolled in the nursing home setting decreased by about 250 between October 2005 and April 2008. During this period nursing home capacity also decreased, by a total of 140:

Oct-05	Orleans	Newport Health Care Center	-10
Jan-06	Windsor	Mt. Ascutney Health Center	-8
Sep-06	Orange	Menig Extended Care	+10
Oct-06	Chittenden	Burlington Health & Rehab.	-42
Feb-07	Lamoille	Morrisville Genesis	-90

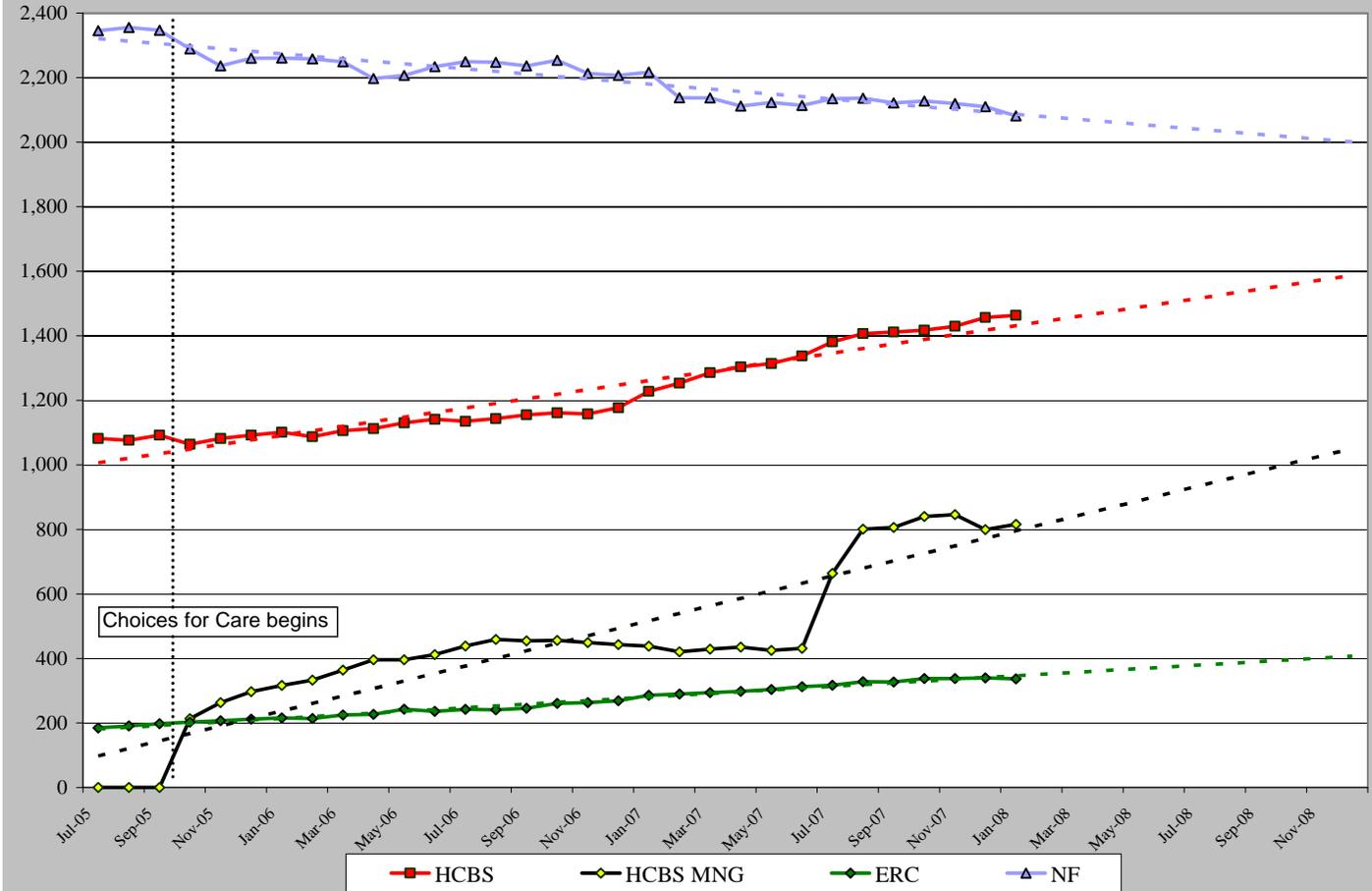
Home and Community Based Services (Highest/High Needs Groups): between October 2005 and April 2008, the number of people enrolled increased by 531.

Enhanced Residential Care: between October 2005 and April 2008, the number of enrolled individuals increased by 172. Some people transitioned to ERC settings from Traumatic Brain Injury Waiver services and nursing homes, contributing to this increase.

HCBS Moderate Needs Group: this ‘expansion’ group was created in October 2005, and by April 2008 had grown to include more than 1000 people. Large increases in Moderate Needs Group enrollment in sfy2008 (app. 500 people) were supported by an increase in MNG funding for Homemaker services.

Choices for Care: Numbers of People Served by Setting, July 2005 - April 2008

data source: EDS paid claims, by dates of service; excludes moderate needs group

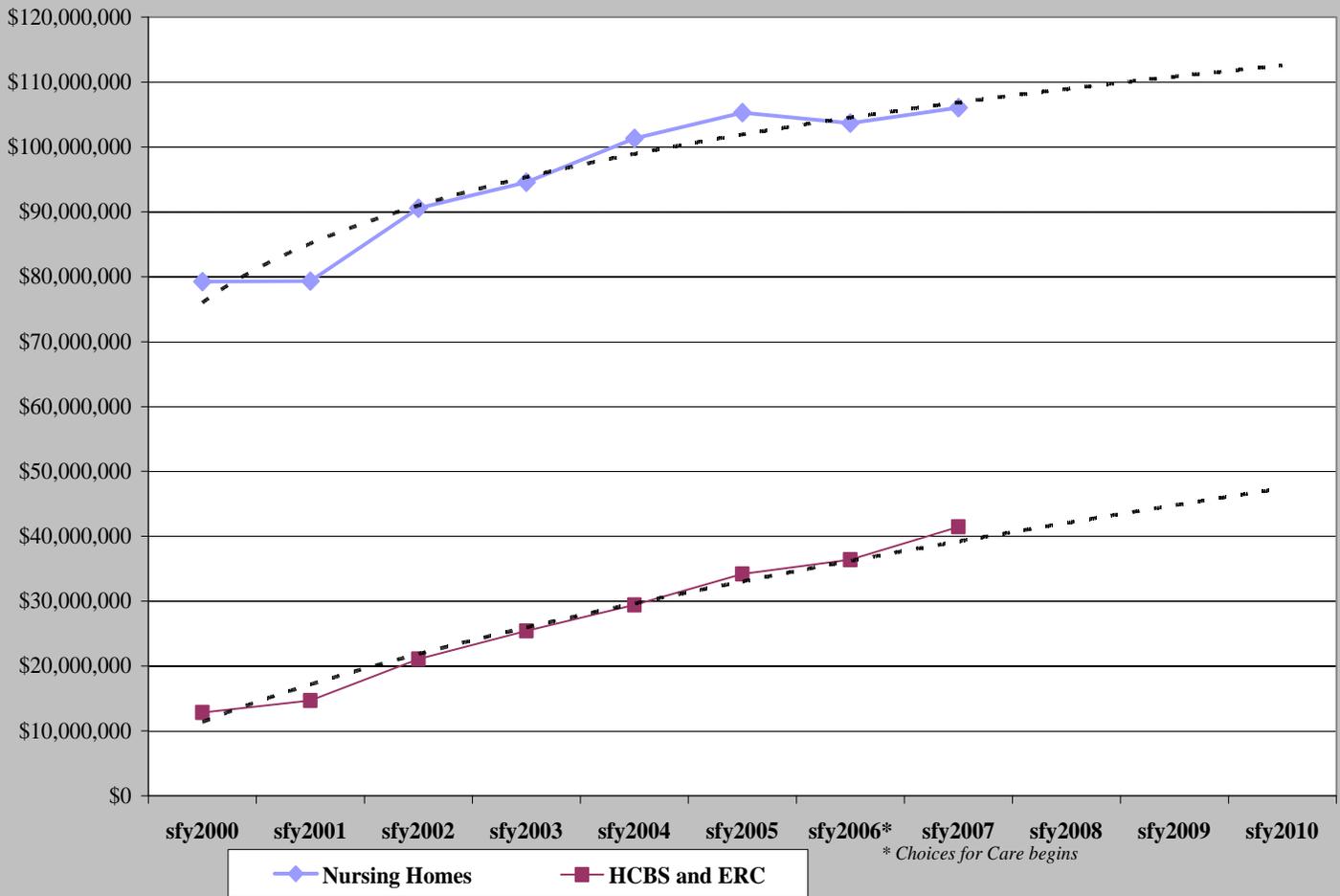


Data source: EDS paid claims, by date of service

This graph shows trends in the numbers of people served by setting, using Medicaid paid claims data. Medicaid paid claims data represents the long term care services that are actually provided, the most accurate source for most Medicaid service data. Note that the nursing home claims data includes Vermont nursing homes, Vermont swing beds, and out-of-state nursing homes.

This shows the same patterns seen in other data sources: decreasing use of nursing home services accompanied by increasing use of Home and Community-based services and Enhanced Residential Care.

Vermont LTC Expenditures by Type, sfy2000-sfy2007



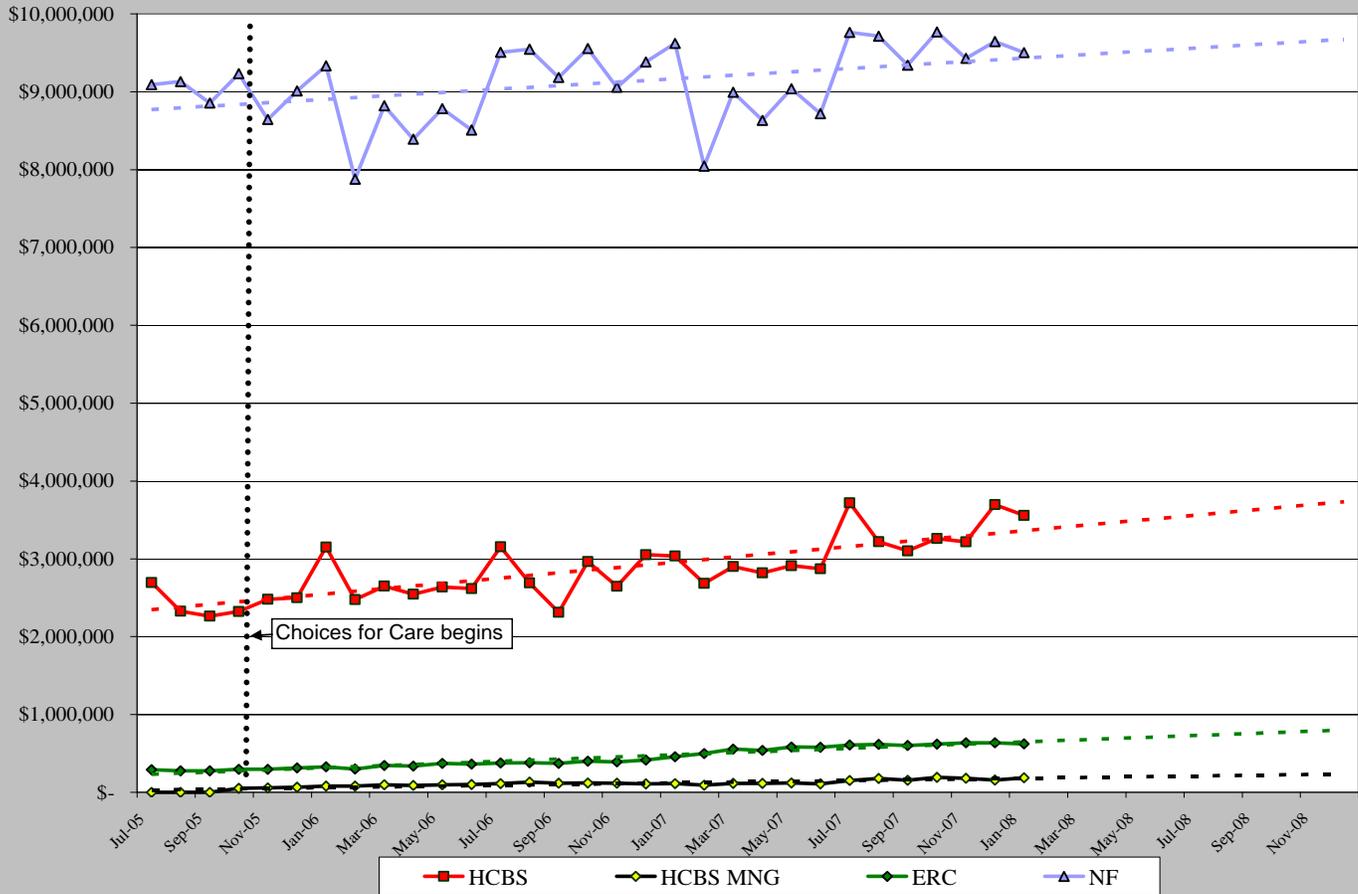
Data source: DAIL Monthly Monitoring Report, federal financial reporting

This graph shows direct Medicaid long term care expenditures by setting. Since sfy2000, Medicaid expenditures have increased about \$30 million in both nursing homes and in alternative settings.

Note that other expenditures are also relevant. People in the HCBS setting tend to incur substantial expenditures for Medicare services, Medicaid services, and other supports that are not provided through home-based long term care services – including housing subsidies, transportation, food, and utilities. People in nursing homes and enhanced residential care tend to incur fewer of these other expenditures.

Choices for Care: Payments by Setting, July 2005 - April 2008

data source: EDS paid claims, by dates of service; excludes moderate needs group



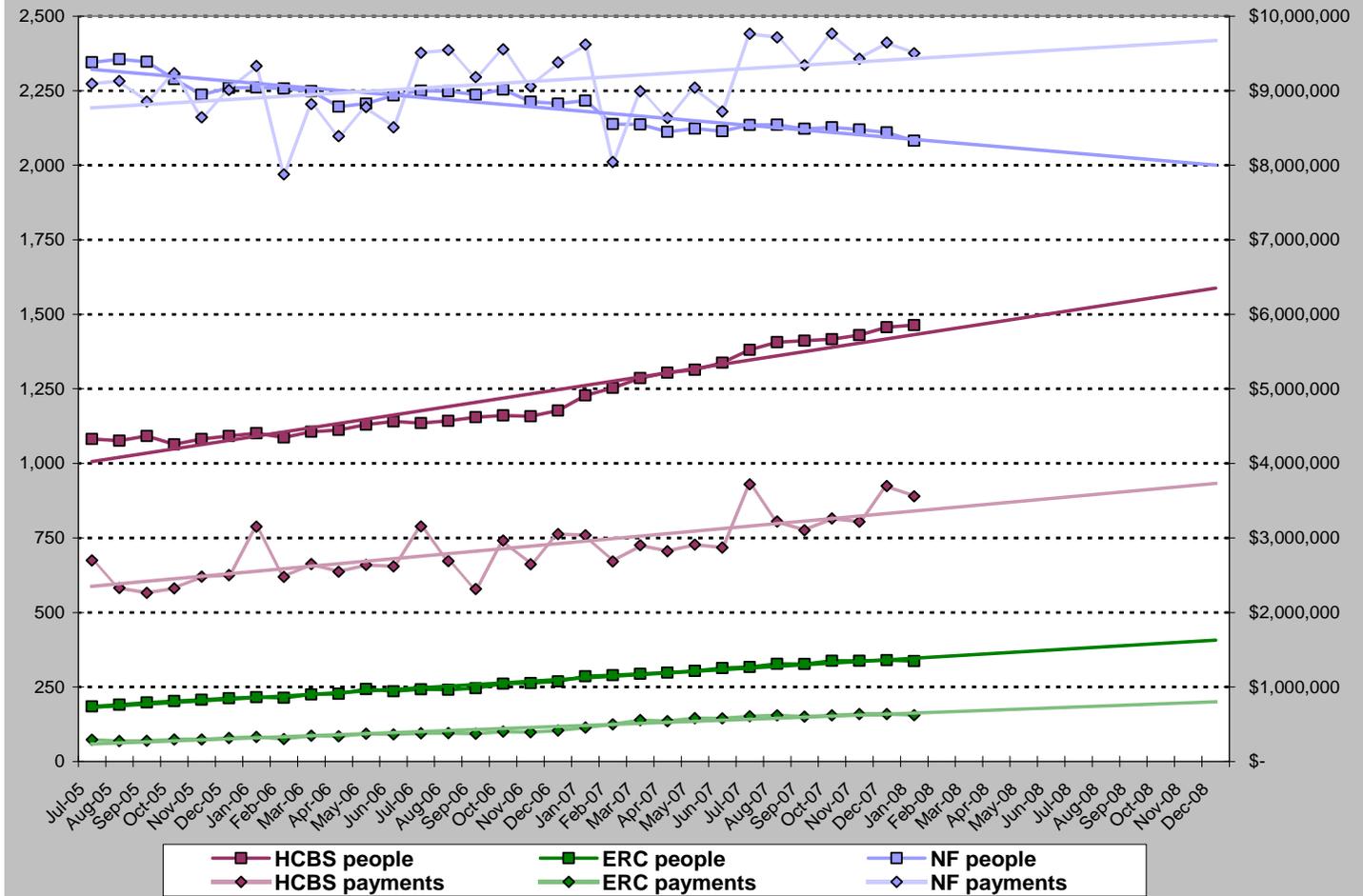
Data source: DAIL Monthly Monitoring Report, federal financial reporting

This graph shows monthly Medicaid long term care payments by setting. These payment figures are adjusted to include third party payments and other cash adjustments, including estate recovery.

Nursing Facilities (NF) currently represent about 70% of long term care expenditures. Home and Community-based Services (HCBS) and Enhanced Residential Care (ERC) expenditures represent about 30%. In comparison, about 55% of Highest and High Needs participants are served in Nursing Facilities, and about 45% are served in alternative settings.

Monthly expenditures for Enhanced Residential Care have increased about \$500,000 per month since July 2005. In the same time period, monthly Home and Community-based Services expenditures have increased about \$1,000,000, and Nursing Facility expenditures have increased about \$750,000.

Choices for Care: People Served and Payments by Month, sfy2006-sfy2008



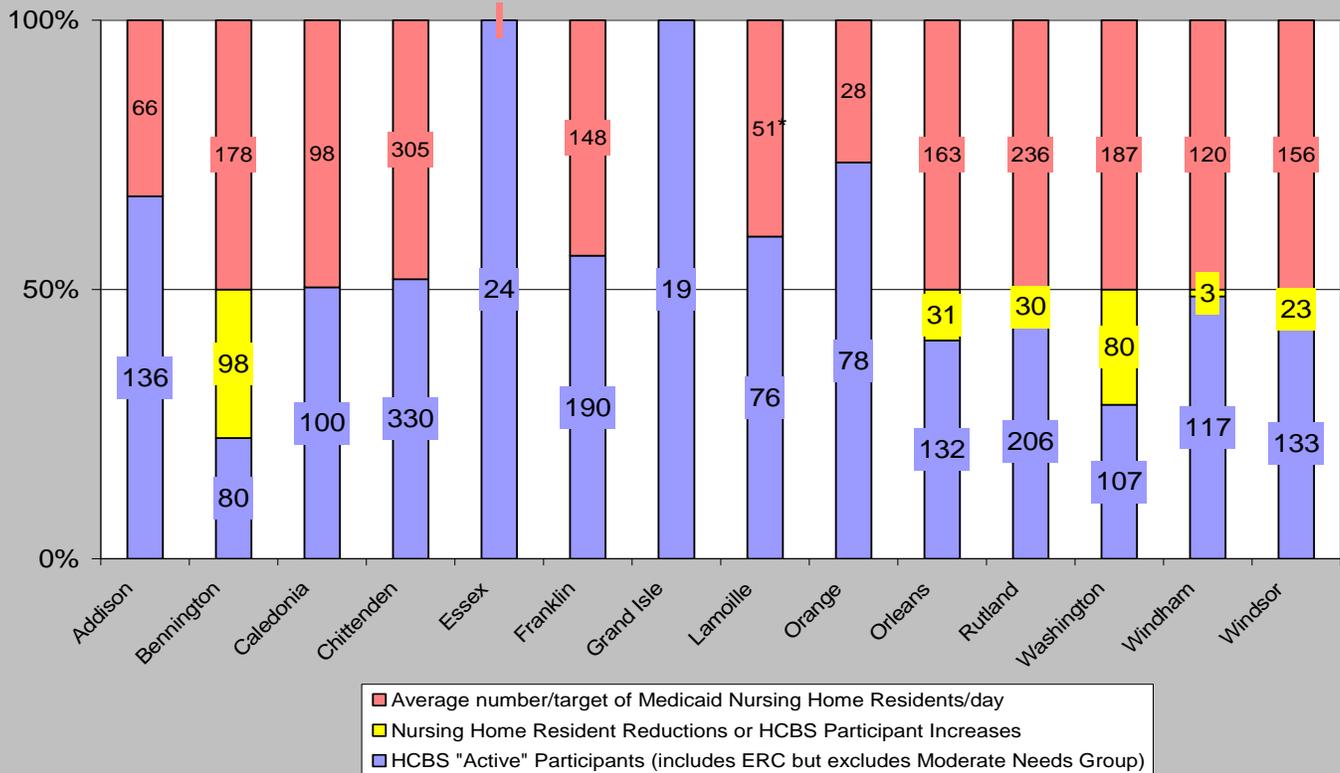
Data source: EDS paid claims, by date of service

This shows trends in numbers of people served and payments by setting for the Highest Needs Group and the High Needs Group. The combination of the two measures reveals:

- NF: the number of people served has decreased significantly; payments have increased
- HCBS: the number of people served has increased significantly; payments have increased at a slower rate
- ERC: the number of people served has increased significantly; payments have increased at a slower rate

These trends present a challenge to the financing of Choices for Care. While the number of people served in nursing homes has decreased, payments to nursing homes continue to increase. The ongoing increase in nursing home payments appears to be a factor in the resurrection of the high needs waiting list. In short, while reducing the number of people served in nursing homes has avoided some long term care costs, it has not actually reduced payments to nursing homes.

Medicaid *Choices for Care*: Nursing Home Residents and Home & Community-Based Participants--January 2008 Changes (Yellow) Needed to Achieve At Least **50%** HCBS



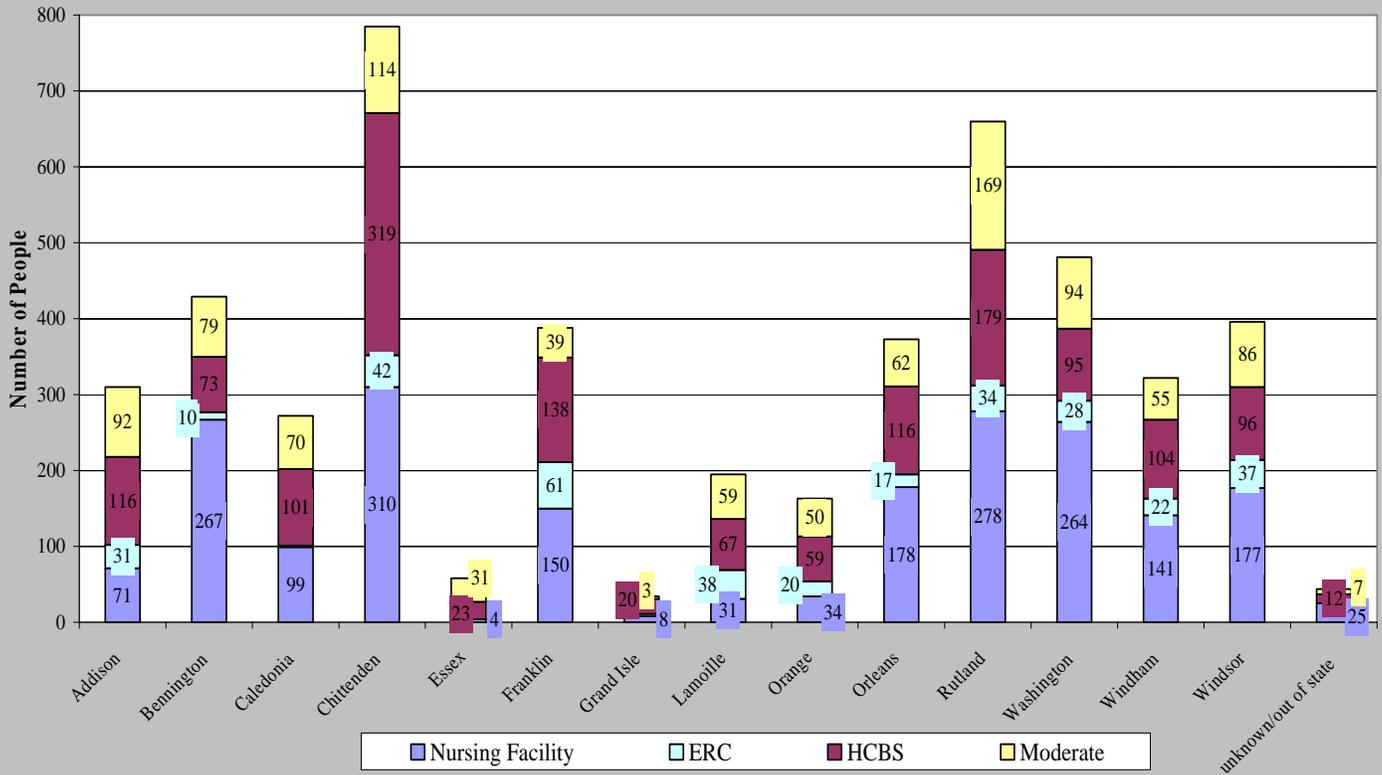
Data sources: DAIL/DDAS SAMS database; Division of Rate Setting.

One of the intended outcomes of *Choices for Care* is that a higher percentage of people who use Medicaid-funded long term care will choose community settings, while a lower percentage will choose nursing homes. This graph illustrates the relative use of nursing homes and alternate settings in each county as of January 2008.

The graph shows the number of *Choices for Care* participants who were served in nursing home settings (blue), the number served in alternative settings (red), and the number of participants who would have to move from a nursing home setting to an alternative setting to reach the benchmark of 50% in alternative settings (yellow). This is based on a performance “benchmark” for at least 50% of the people who use Medicaid long term care to be served in a home and community-based setting.

In eight counties (Addison, Caledonia, Chittenden, Essex, Franklin, Grand Isle, Lamoille, and Orange), more than 50% of *Choices for Care* participants are served in alternative settings. People in the remaining counties (Bennington, Orleans, Rutland, Washington, Windham, and Windsor) remain more reliant on nursing homes, with less than 50% served in alternative settings. People in Bennington and Washington Counties are the most reliant on nursing homes.

**Choices for Care: Enrolled Participants by Setting by County
as of April 2008**



Data source: DAIL/DDAS SAMS database.

This graph shows the settings in which Choices for Care participants are served, by county. The graph can be used to compare the numbers of people served in each setting within each county, as well as the numbers of people served across all counties. Chittenden County, with the largest population in Vermont, has the highest number of Choices for Care participants. Rutland County has the second largest population and the second highest number of Choices for Care participants.

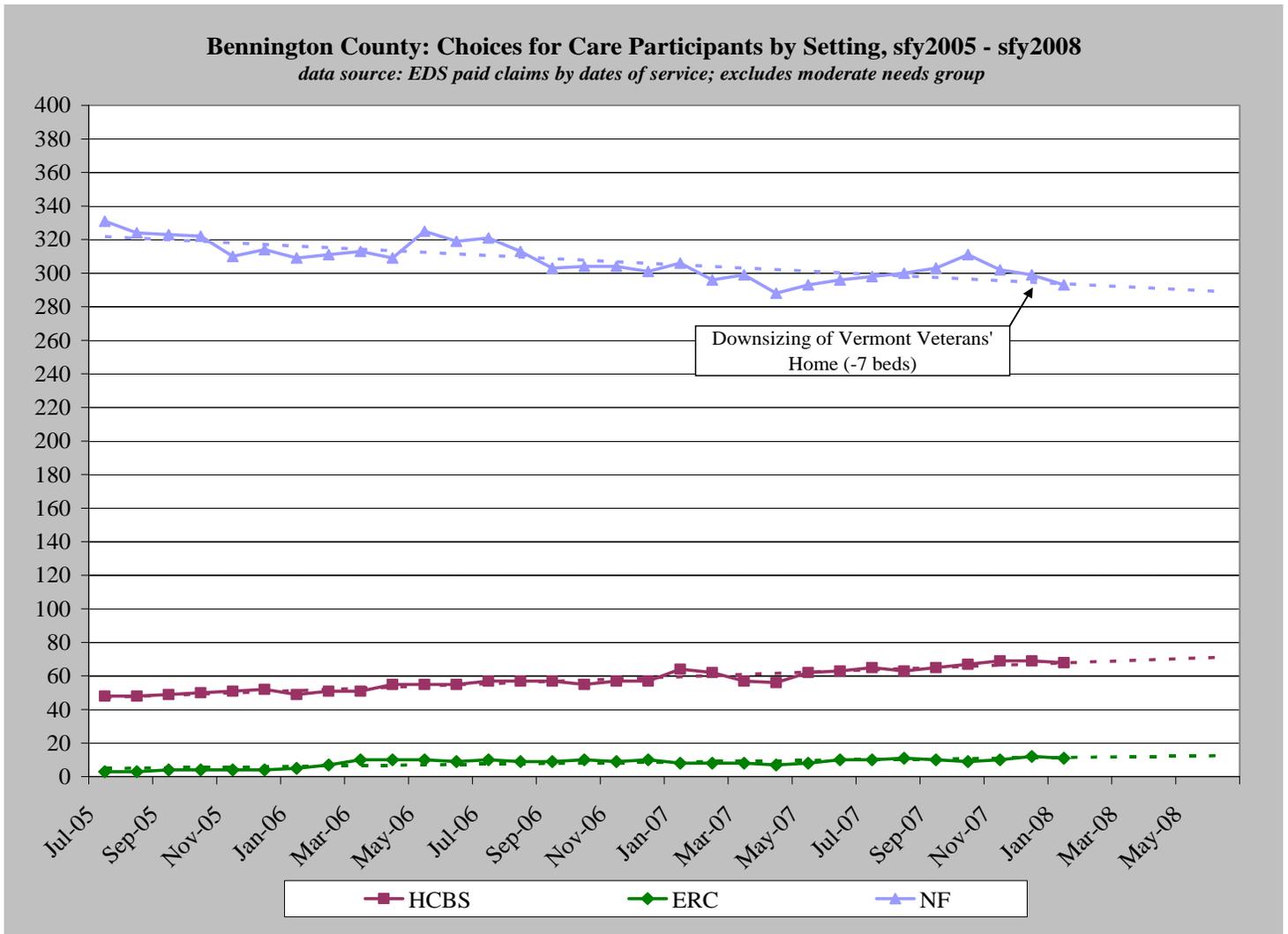
In Addison, Lamoille, and Orange Counties, a relatively large proportion of people in the Highest and High Needs Groups are served in the HCBS and ERC settings. In Bennington, Orleans, Rutland, Washington and Windsor Counties, a relatively large proportion of people in the Highest and High Needs Groups are served in nursing facilities.

The graphs on the following pages show the history of the use of the three settings in each county. The counties are grouped together by the numbers of people using long term care services, allowing comparisons between counties that have some relative similarity. Note that the number of people using long term care services size of the long term care population in a county may not reflect the size of total population in the county.

Large counties: Bennington, Chittenden, Rutland, Washington, Windsor

Medium counties: Franklin, Orleans, Windham

Smaller counties: Addison, Caledonia, Essex, Grand Isle, Lamoille, and Orange

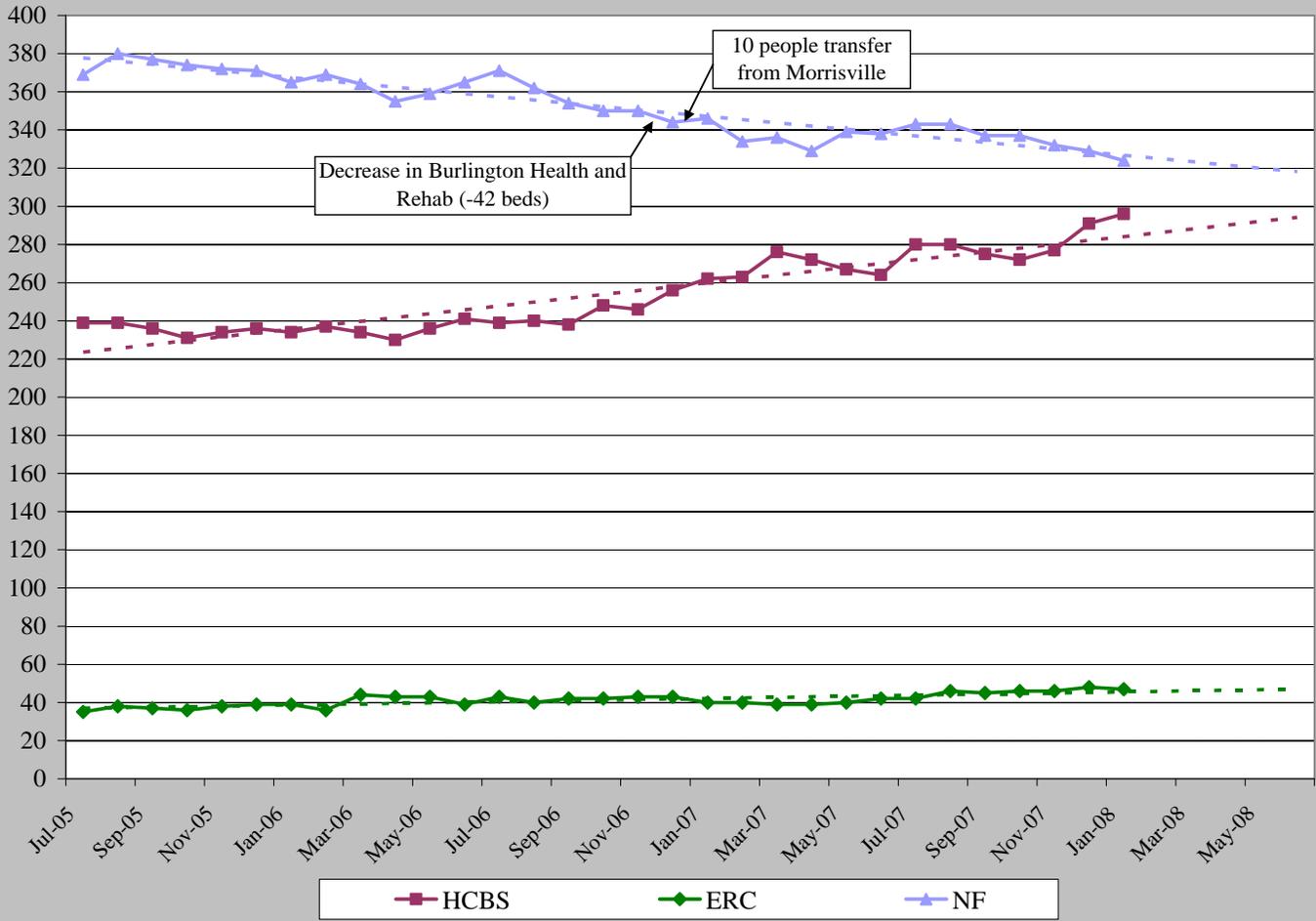


Data source: EDS paid claims

In Bennington County, use of both HCBS and ERC has increased slowly since July 2005. The use of nursing homes has slowly declined. This is the intended outcome of Choices for Care.

Chittenden County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

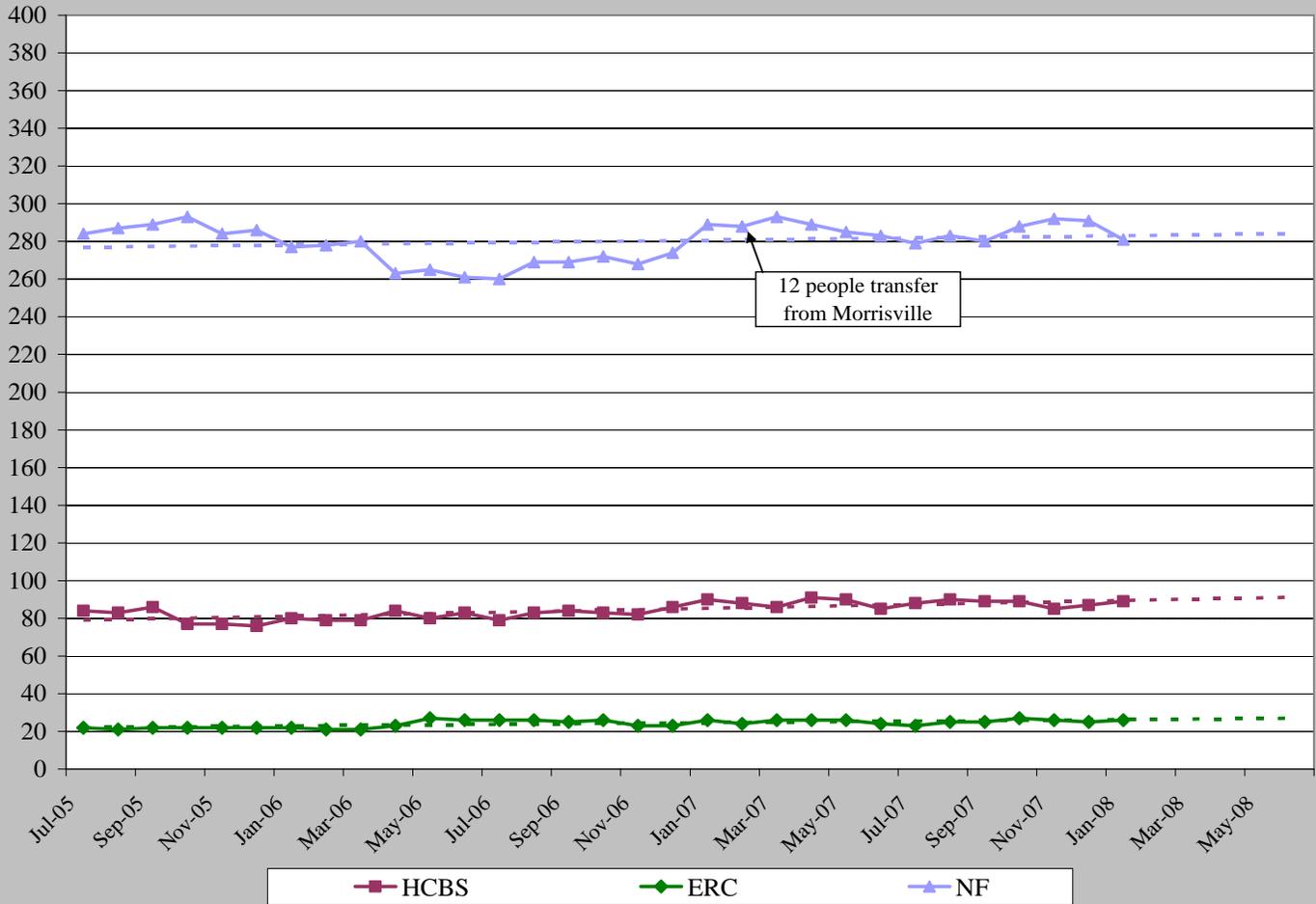


Data source: EDS paid claims

In Chittenden County, use of both HCBS and ERC has increased slowly since July 2005. The use of nursing homes has slowly declined. This is the intended outcome of Choices for Care.

Washington County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

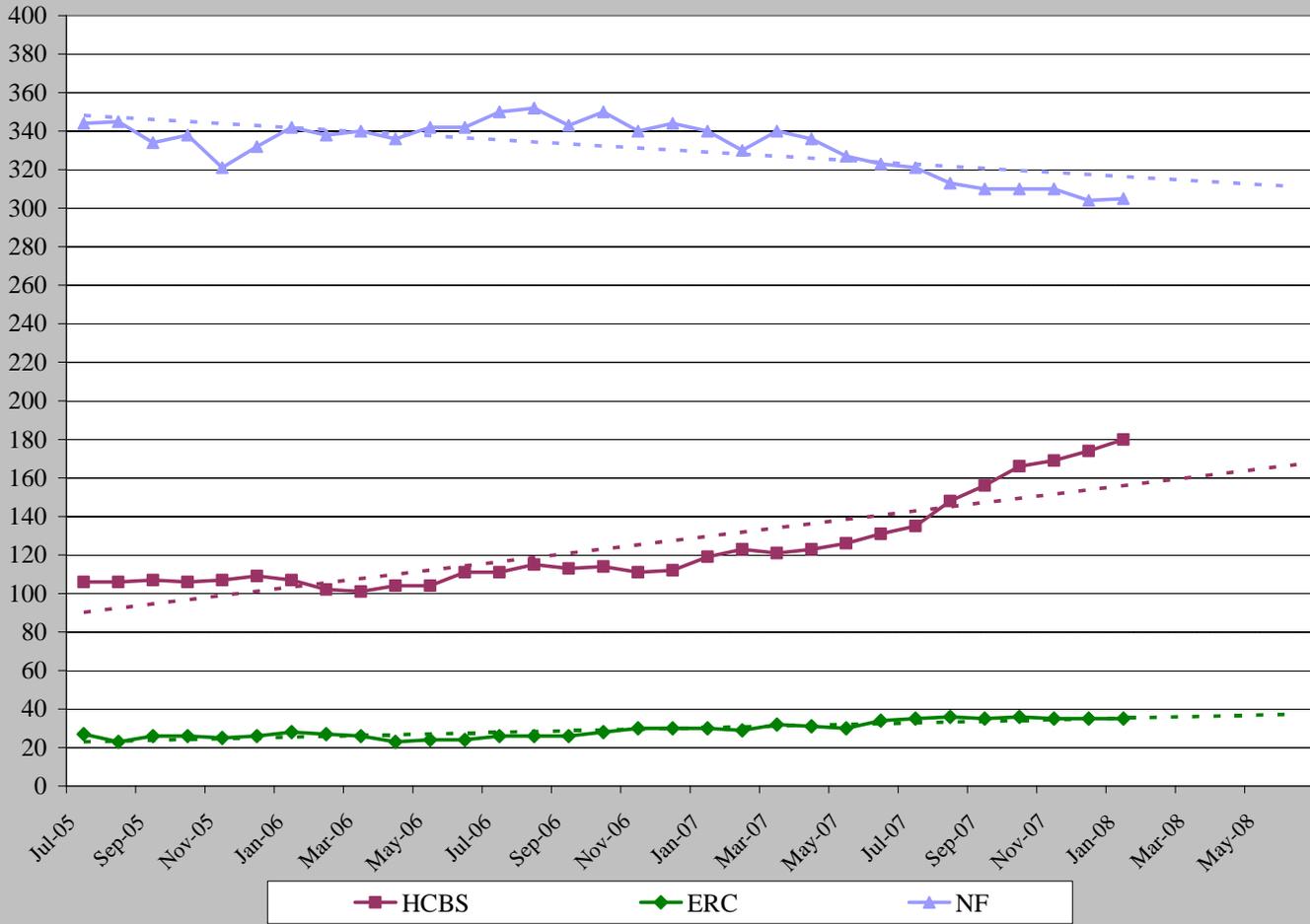


Data source: EDS paid claims

In Washington County, use of both HCBS and ERC has increased slowly since July 2005. The use of nursing homes slowly declined between July 2005 and August 2006, but slowly increased since then. Because Washington County nursing facilities are close to Lamoille County, 12 residents transferred from Lamoille County to Washington County upon the closing of the Morrisville nursing facility. While residents of Lamoille County may contribute to the use of nursing homes, it appears that the intended outcome of Choices for Care has not been realized in Washington County.

Rutland County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

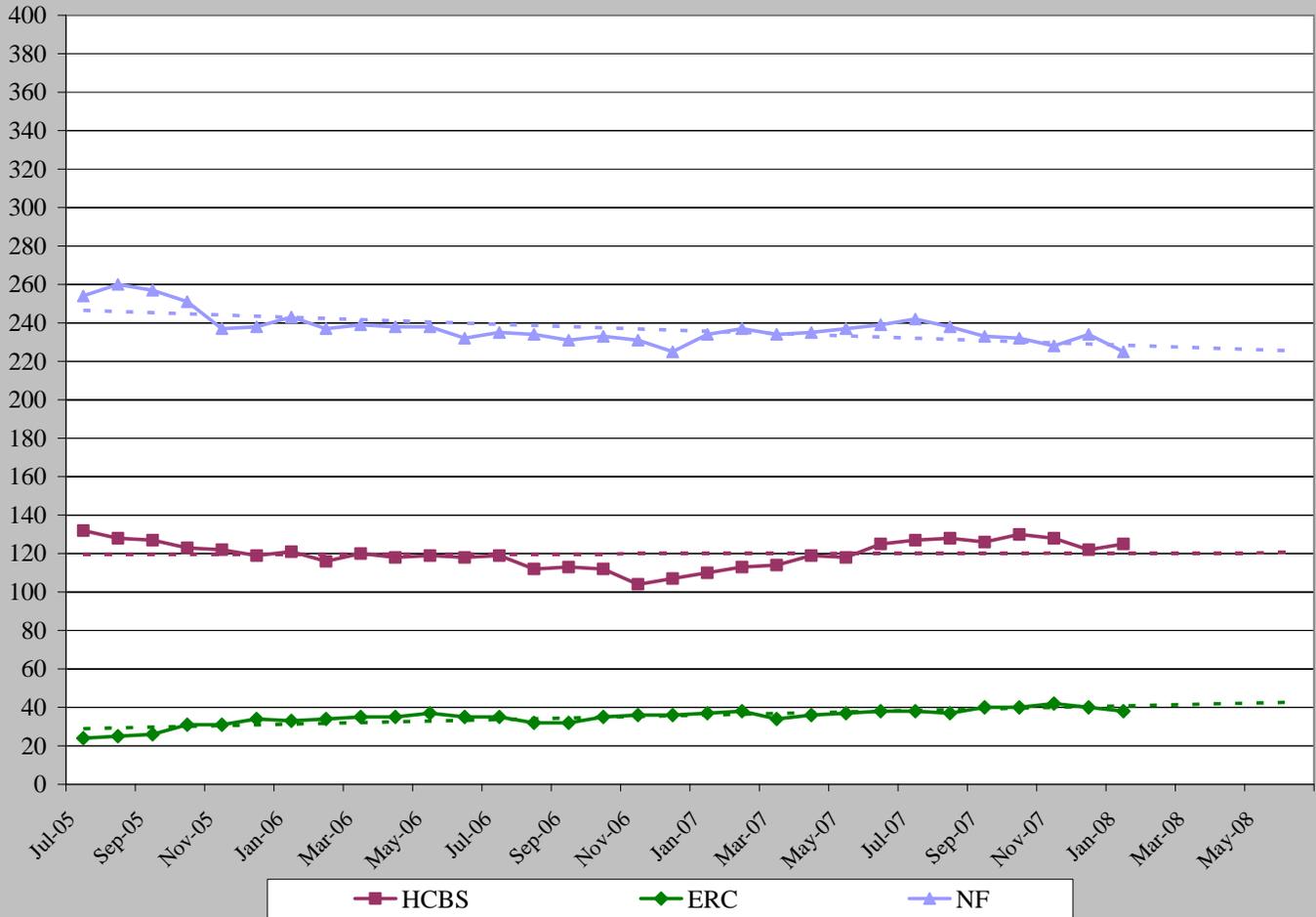


Data source: EDS paid claims

In Rutland County, use of both HCBS and ERC has increased since July 2005; the rate of growth in the use of the HCBS setting has increased noticeably in the last year. The use of nursing homes has slowly declined, also at an increased pace in the last year. This is the intended outcome of Choices for Care.

Windsor County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

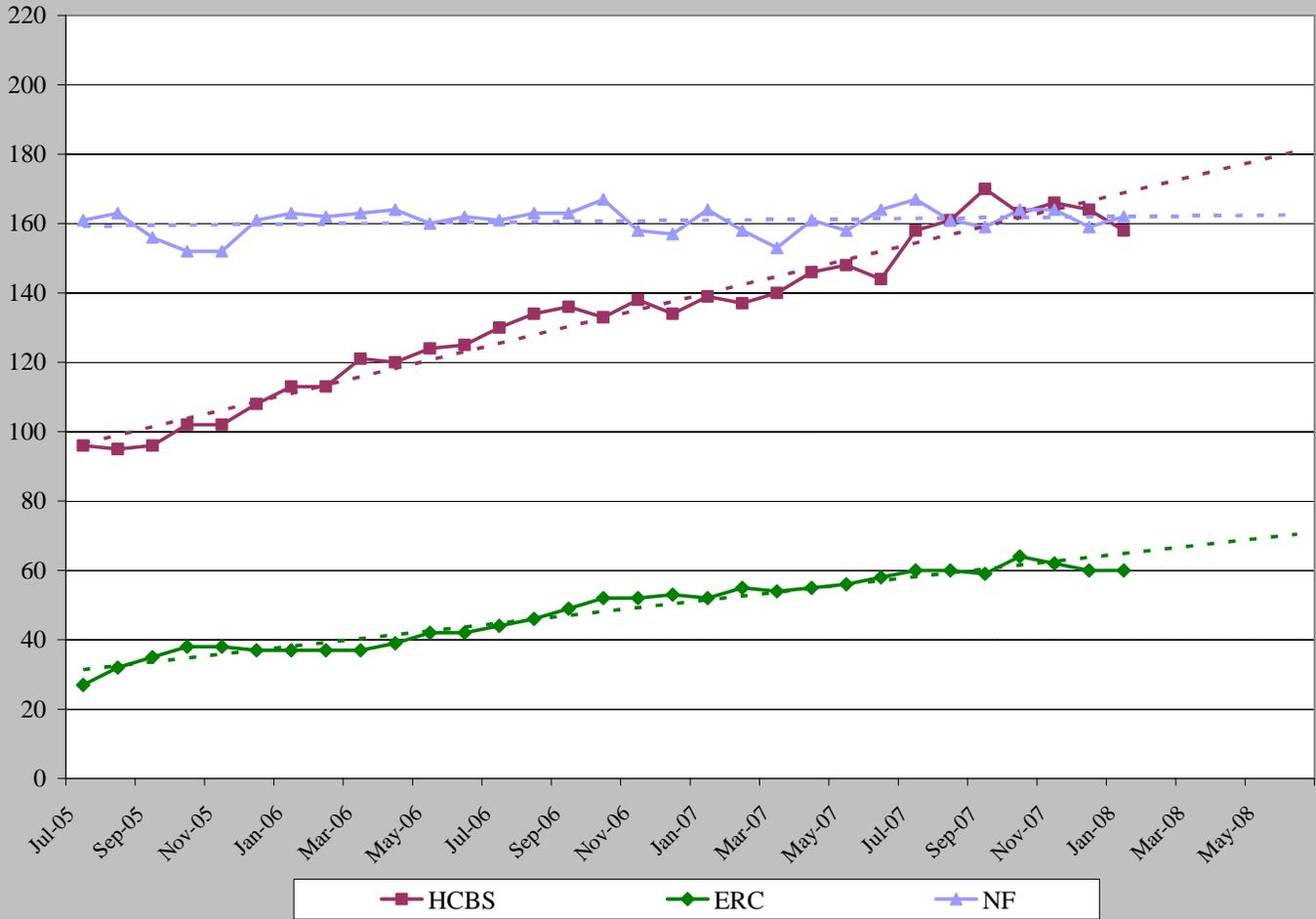


Data source: EDS paid claims

In Windsor County, use of ERC has increased since July 2005. The use of HCBS decreased slightly between July 2005 and December 2006, but has increased slightly since then. The use of nursing homes has slowly declined. This is the intended outcome of Choices for Care.

Franklin County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

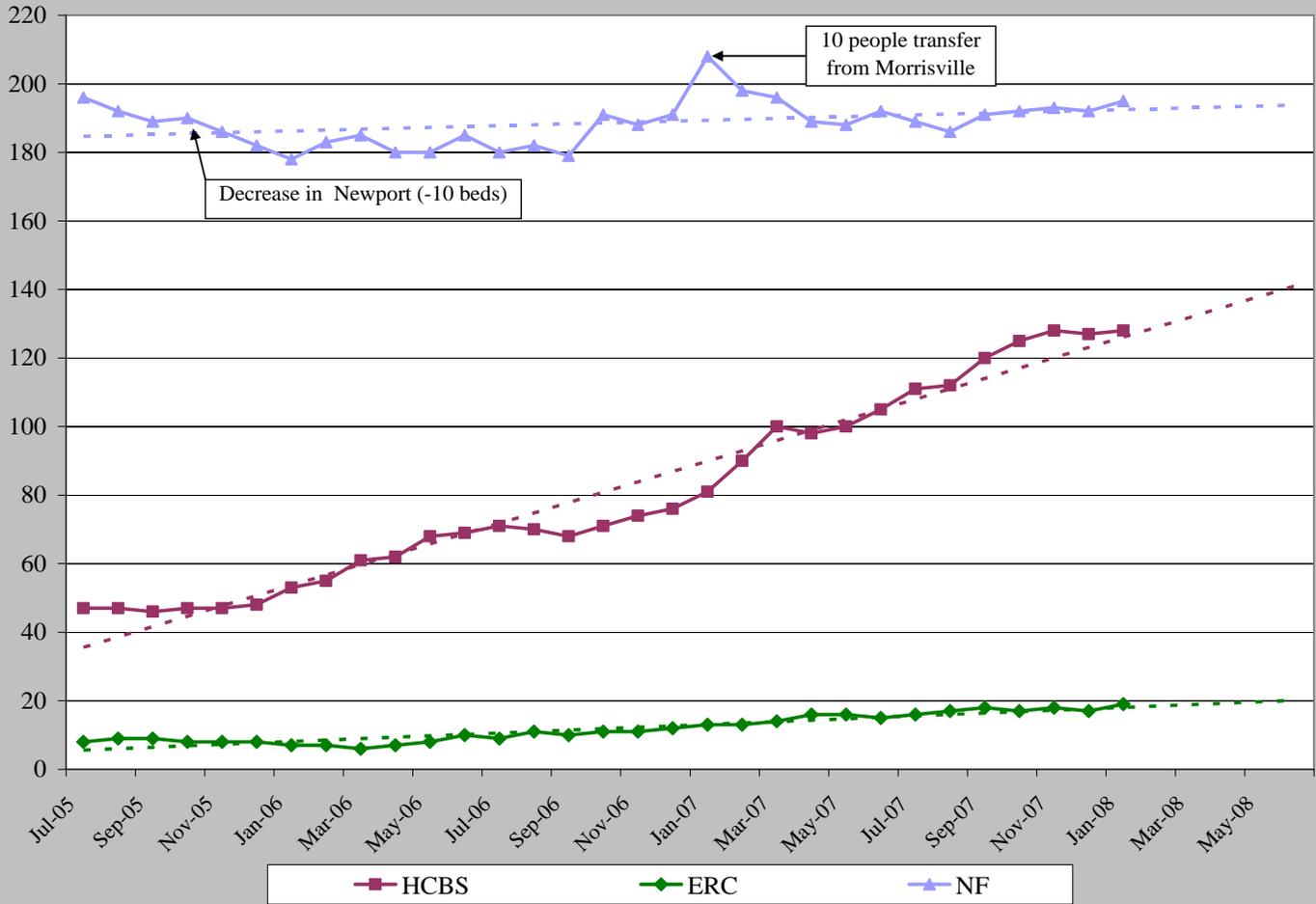


Data source: EDS paid claims

In Franklin County, use of both HCBS and ERC has increased steadily since July 2005. However, the use of nursing homes has remained stable. In spite of growth in the use of alternate settings, it appears that the intended outcome of Choices for Care has not been realized in Franklin County.

Orleans County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

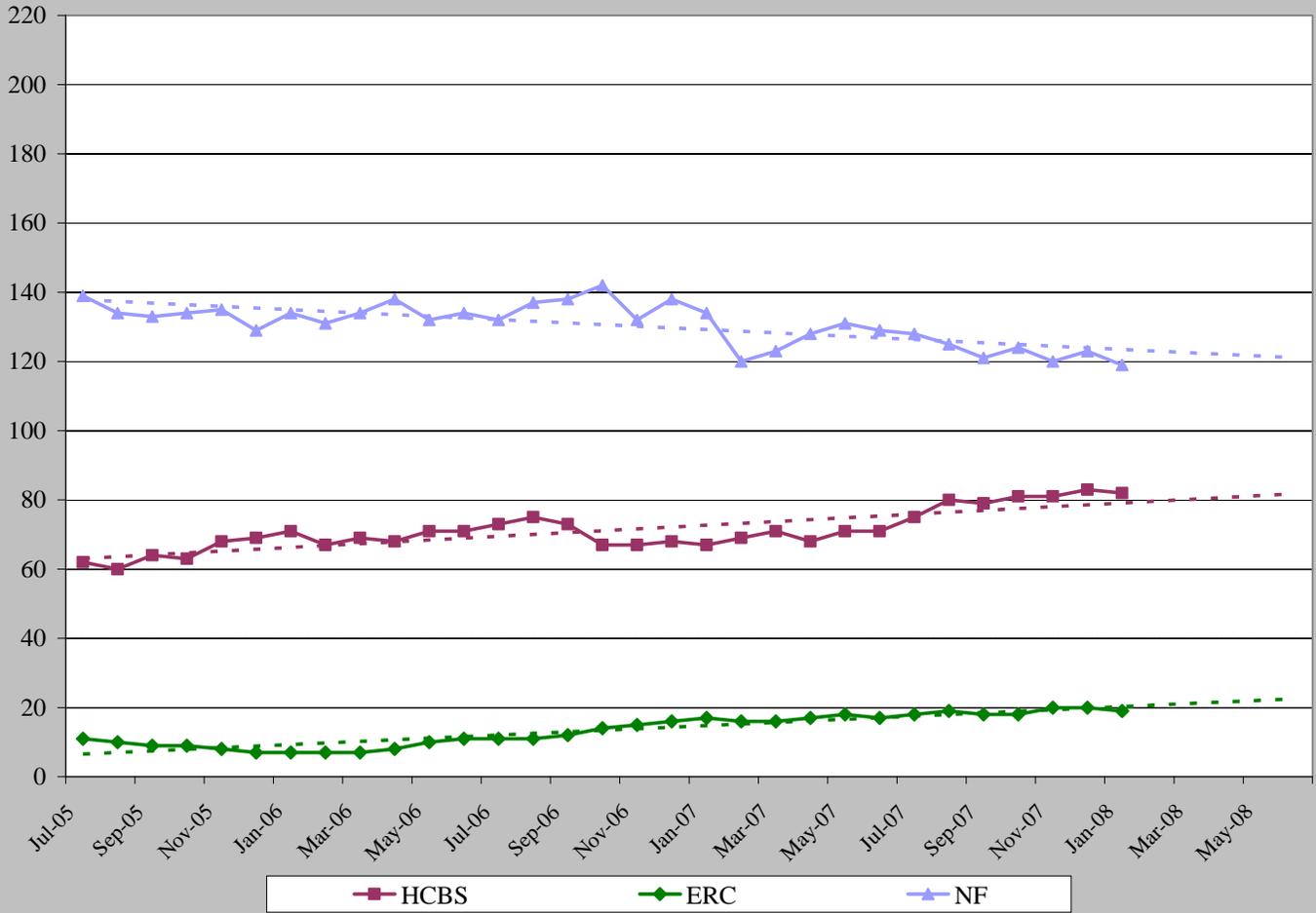


Data source: EDS paid claims

In Orleans County, use of both HCBS has increased steadily since July 2005, while use of ERC has grown very slowly. However, the use of nursing homes has actually increased. The transfer of 10 people from Lamoille County at the closing of Morrisville in January 2007 had a small effect on the use of nursing homes in Orleans County. However, the use of nursing homes by other people has also increased. It appears that the intended outcome of Choices for Care has not been realized in Orleans County.

Windham County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

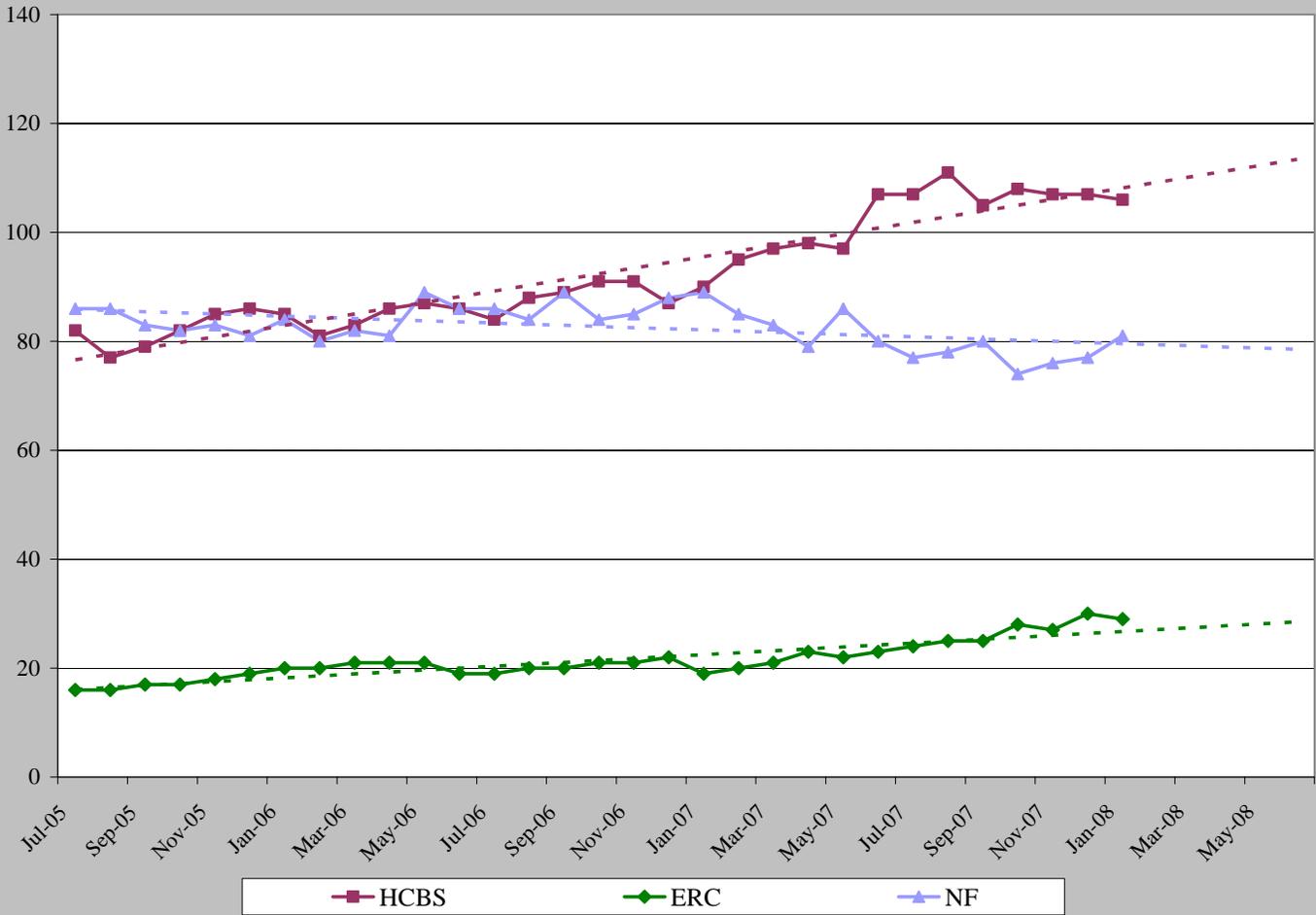


Data source: EDS paid claims

In Windham County, use of both HCBS and ERC has increased slowly since July 2005. The use of nursing homes has slowly declined. This is the intended outcome of Choices for Care.

Addison County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

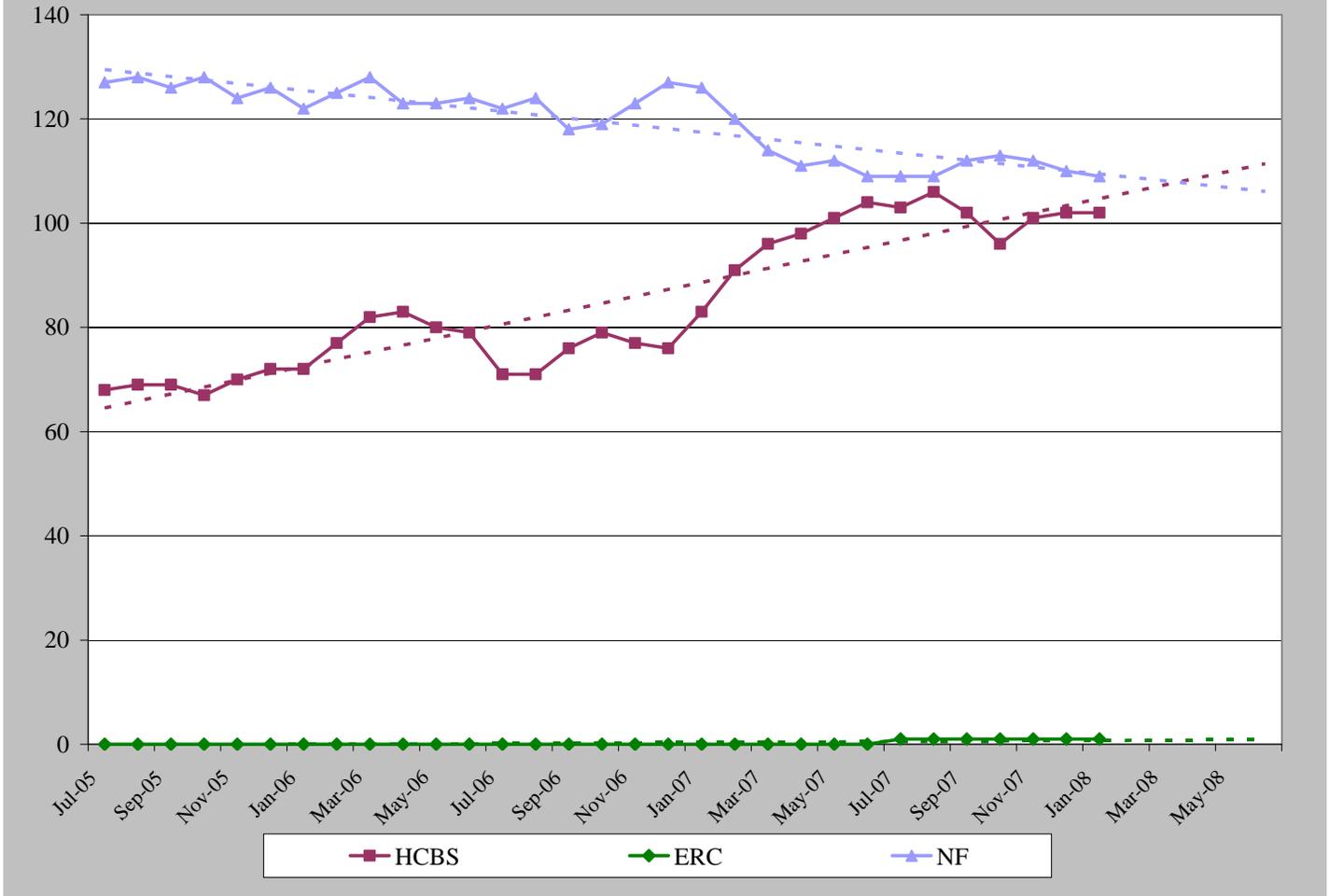


Data source: EDS paid claims

In Addison County, use of both HCBS and ERC has increased slowly since July 2005. The use of nursing homes, already low in comparison to other counties, has continued to slowly decline. This is the intended outcome of Choices for Care.

Caledonia County: Choices for Care Participants by Setting, sfy2005 - sfy2008

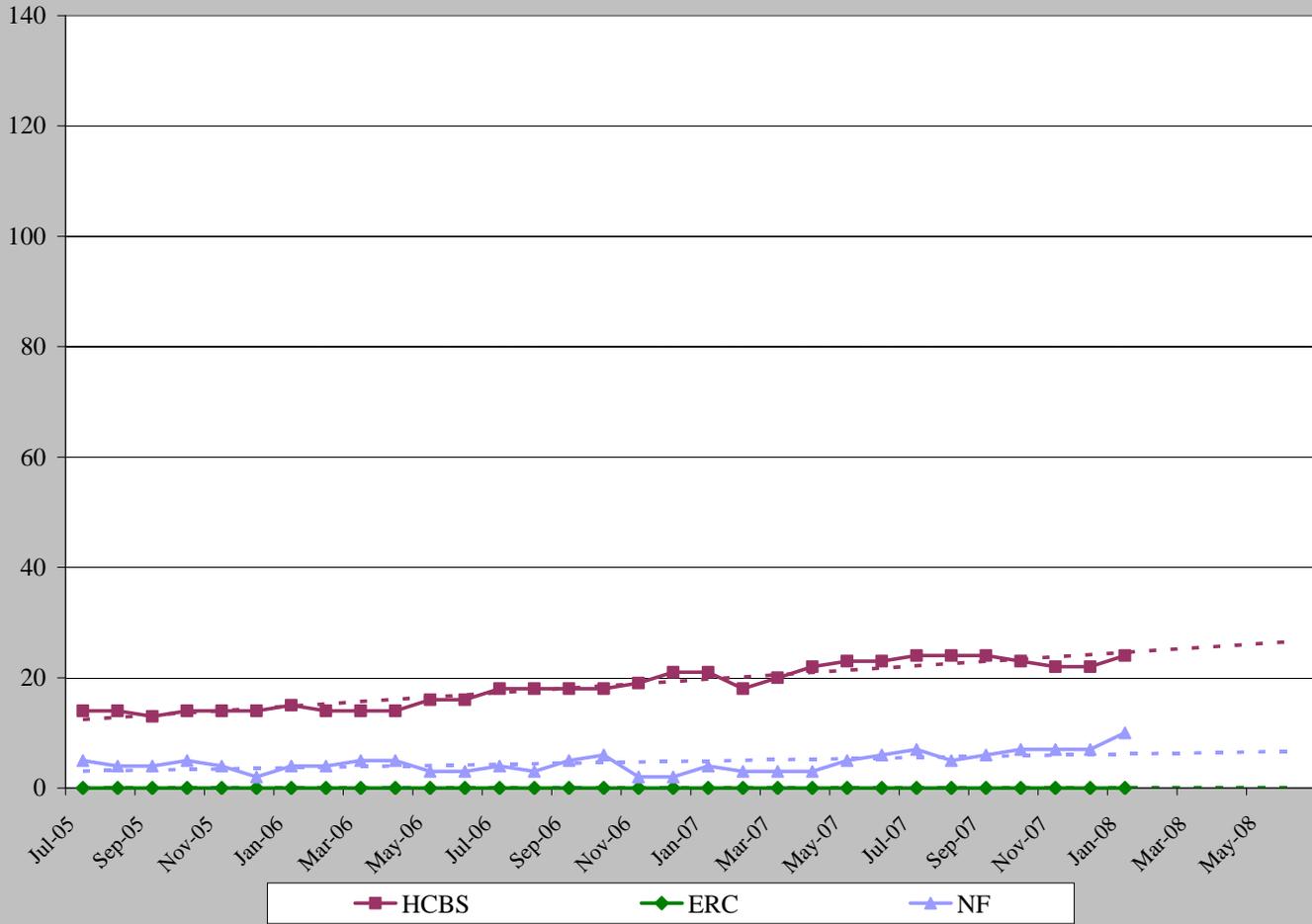
data source: EDS paid claims by dates of service; excludes moderate needs group



Data source: EDS paid claims

In Caledonia County, use of HCBS has increased slowly since July 2005. The use of ERC is close to zero, due to the presence of one small (capacity of 10) participating facility in the county. The use of nursing facilities has slowly declined. This is the intended outcome of Choices for Care.

Essex County: Choices for Care Participants by Setting, sfy2005 - sfy2008
data source: EDS paid claims by dates of service; excludes moderate needs group

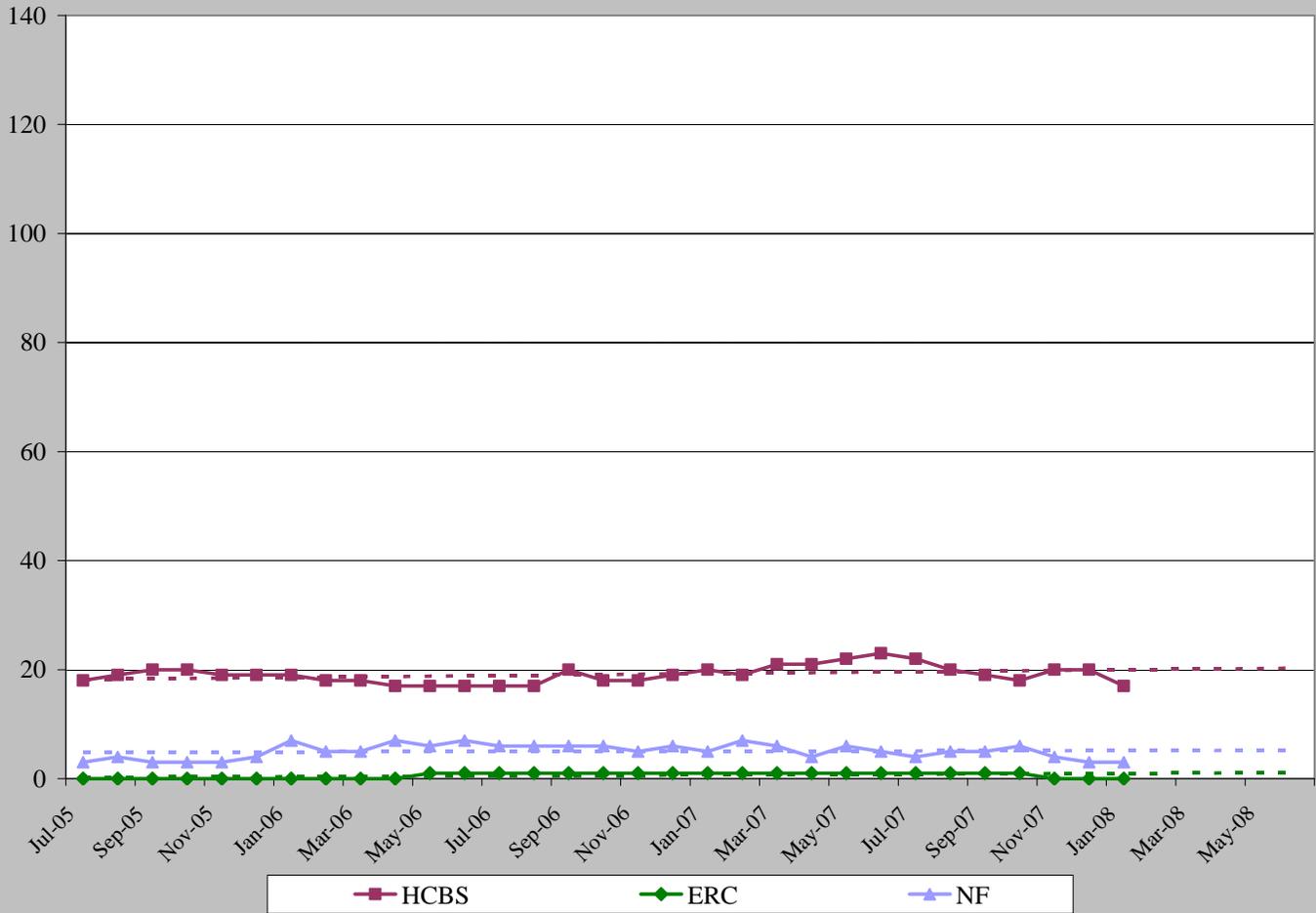


Data source: EDS paid claims

In Essex County, use of HCBS has increased slowly since July 2005. The use of ERC is close to zero, due to the absence of a participating facility in the county. The use of nursing facilities has also slowly increased. Due to the small numbers of people in each setting, it is difficult to determine if the intended effect of Choices for Care has been realized in Essex County.

Grand Isle County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

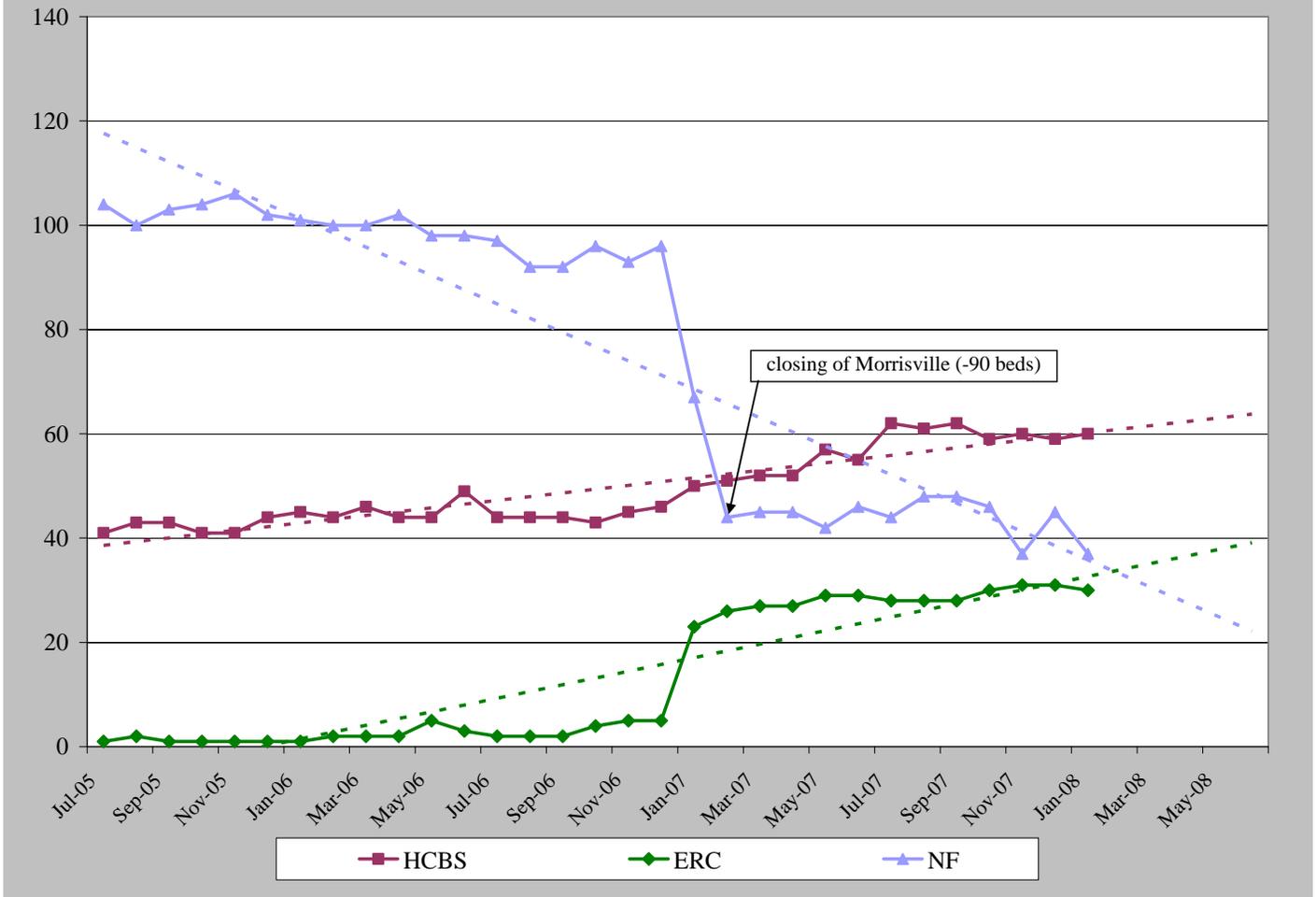


Data source: EDS paid claims

In Grand Isle County, use of HCBS has increased slowly since July 2005. The use of ERC is close to zero, due to the absence of a participating facility in the county. The use of nursing facilities has remained stable. Due to the small numbers of people in each setting, it is difficult to determine if the intended effect of Choices for Care has been realized in Grand Isle County.

Lamoille County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group

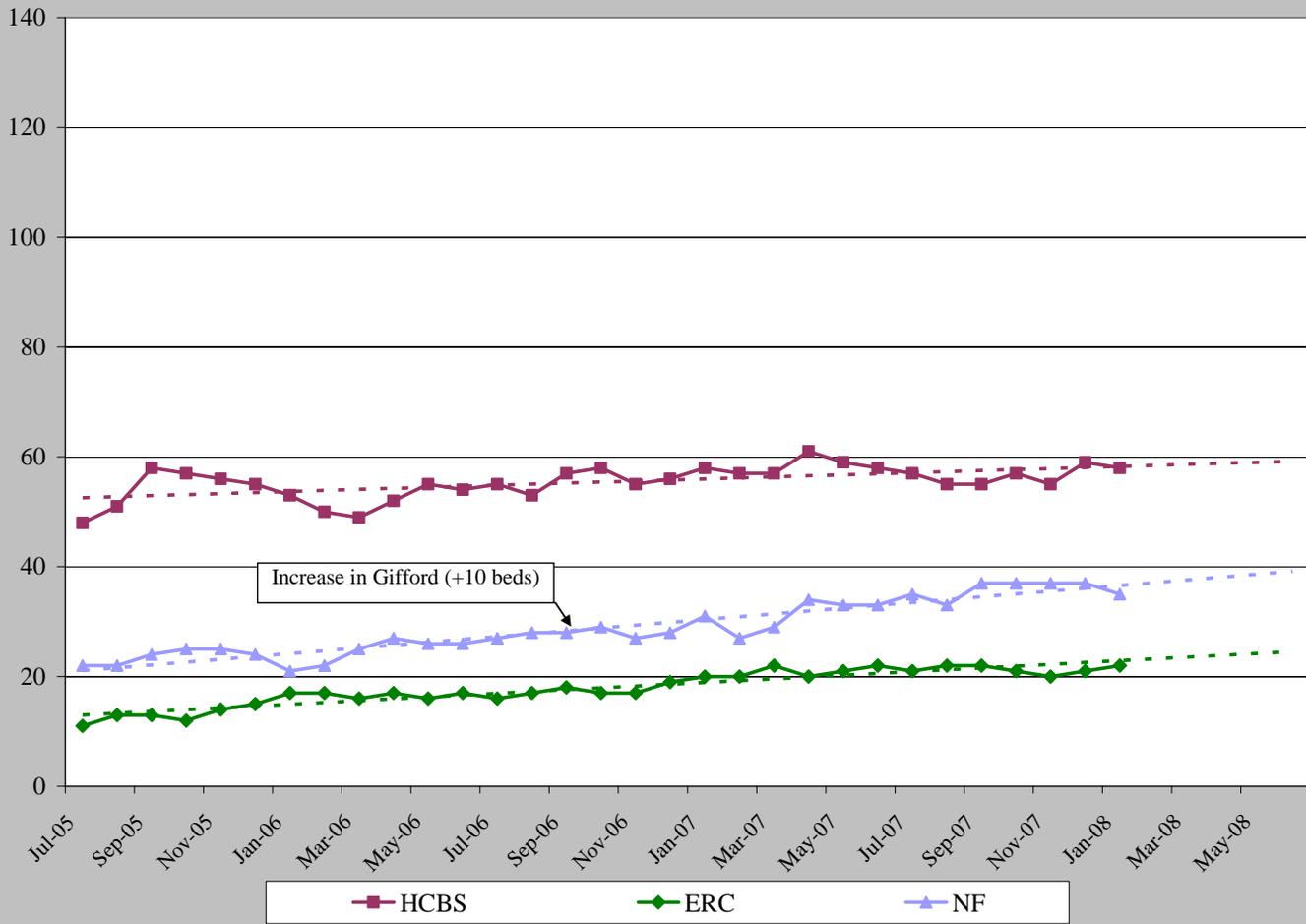


Data source: EDS paid claims

In Lamoille County, use of HCBS has increased slowly since July 2005. The closing of Morrisville in February 2007 caused a significant decrease in the use of nursing homes. This also caused a significant increase in the use of ERC, when some residents moved to Copley Manor Spruce House. While it is not clear if residents of Lamoille contribute to the use of nursing homes in other counties, it appears that the intended effect of Choices for Care has been realized in Lamoille County.

Orange County: Choices for Care Participants by Setting, sfy2005 - sfy2008

data source: EDS paid claims by dates of service; excludes moderate needs group



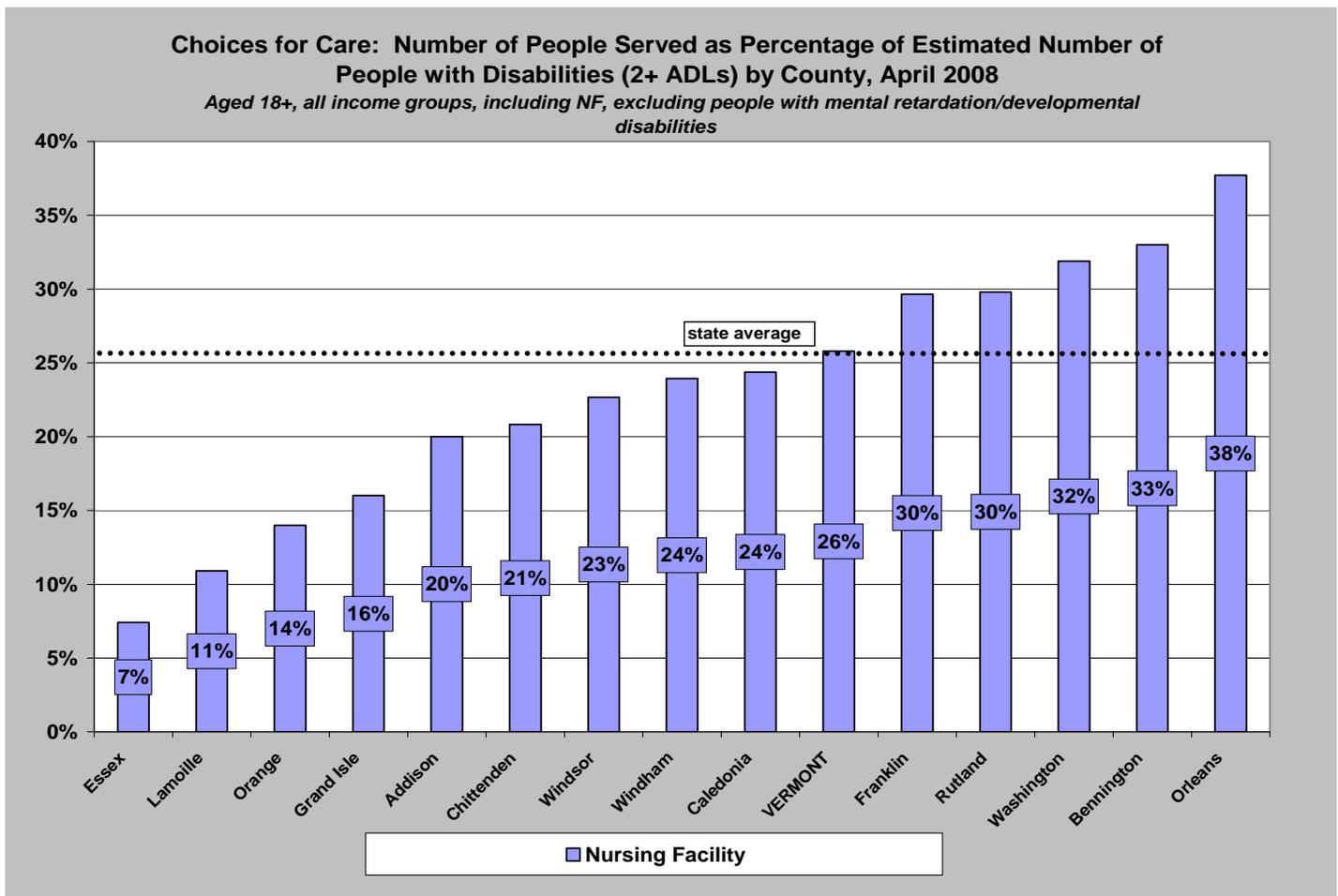
Data source: EDS paid claims

In Orange County, use of both HCBS and ERC has increased slowly since July 2005. However, the use of nursing homes has increased at a faster pace. It appears that the intended outcome of Choices for Care has not been realized in Orange County.

The following graphs provide demographic perspectives on Choices for Care enrollment in each county, based on estimates of total demographic need. The Moderate Needs Group is not included.

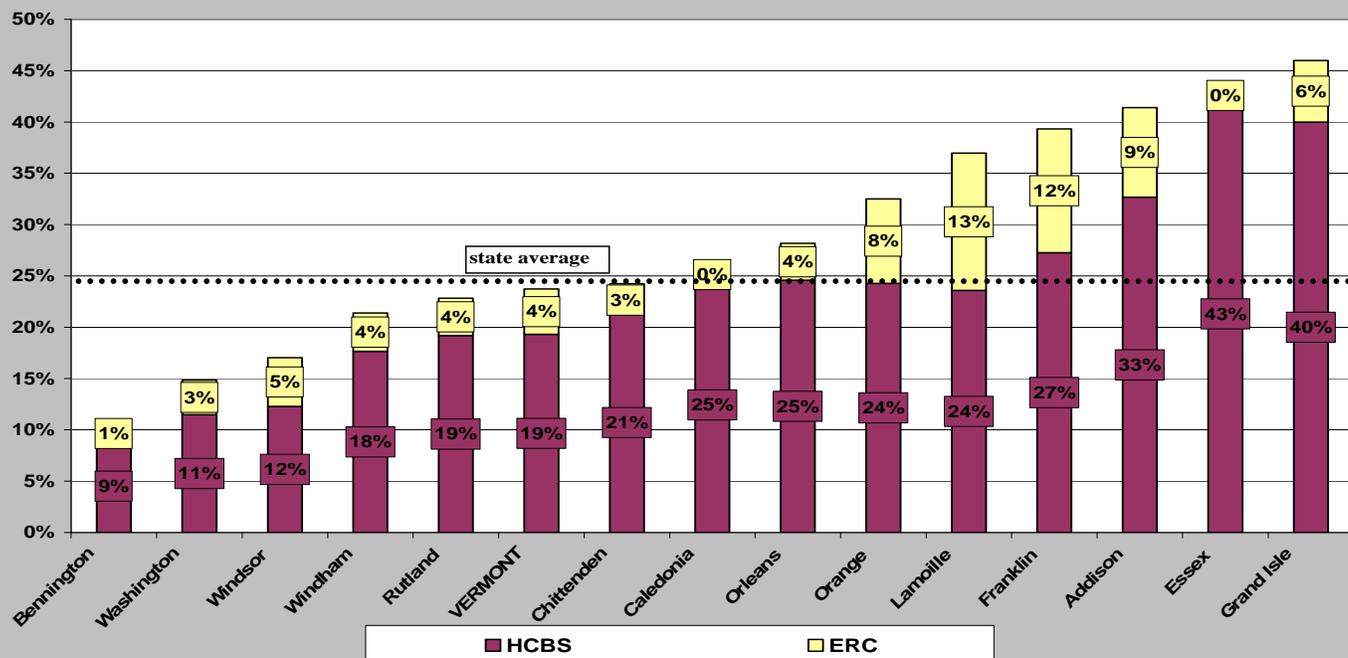
The graphs are based on Shaping the Future of Long Term Care and Independent Living 2006-2016 by Julie Wasserman (May 2007), which includes estimates of need in the nursing home setting, and home and community-based settings. Estimates of the 2006 need in both settings were combined to produce an estimate of total need, including all people aged 18 and over with two or more ADL assistance needs, in all income groups. The total need was then compared to the number served, producing an estimate of the percentage of people in need who are actually served in the different settings.

Note that this estimate of need is for all income groups, including people who are not financially eligible for Choices for Care. The estimate also includes people whose needs are met by other funding sources and programs (Medicare, community Medicaid, private insurance, Traumatic Brain Injury Waiver, Attendant Services Program, Day Health Rehabilitation Services, Community Rehabilitation and Treatment, etc.) Thus, it is not reasonable to attempt to serve 100% of this estimated need through Choices for Care. However, the graphs do describe the relative percentages of people who are served within each county.

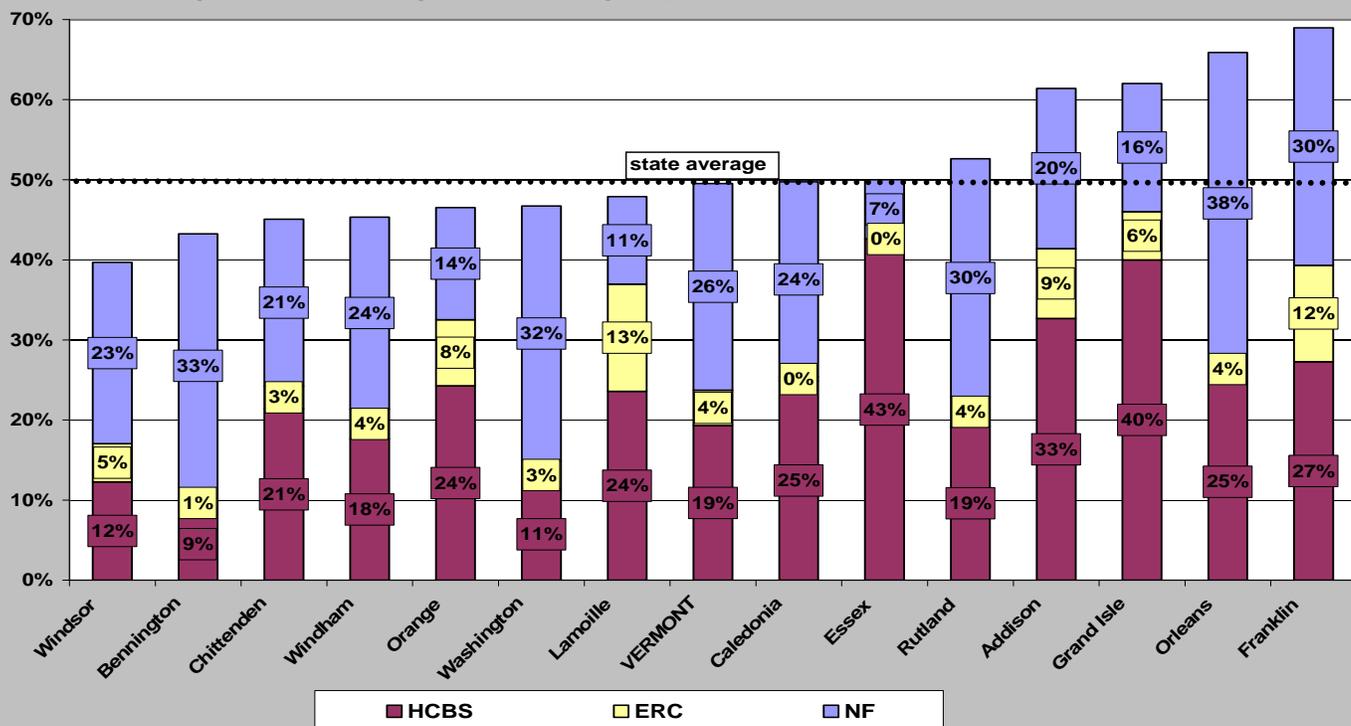


Data sources: DAIL/DDAS SAMS database; *Shaping the Future of Long Term Care and Independent Living 2006-2016*.

Choices for Care: Number of People Served by Setting as a Percentage of Estimated Community Need by County - April 2008
 Aged 18+, all income groups, including NF residents, excluding people with mental retardation/developmental disabilities



Choices for Care: People Served in LTC by Setting as a Percentage of Total Need by County - April 2008
 Aged 18+, all income groups, excluding people with mental retardation/developmental disabilities



Data sources: DAIL/DDAS SAMS database; *Shaping the Future of Long Term Care and Independent Living 2006-2016*

Nursing home capacity is a factor in actual nursing home use, and the use of home and community based services can be related to nursing home capacity. Increased use of home

and community-based services may contribute to bed reductions; conversely, bed reductions may contribute to increased use of home and community-based services. During Choices for Care, the number of available nursing home beds was reduced in Chittenden, Lamoille, Orleans and Windsor Counties. The increased use of home and community-based services appears to have contributed to some of these reductions.

Nursing Facility Bed Supply Changes Since sfy1996 (Act 160)				
Date	Facility	Decreases	Increases	County
Oct 1996	Maple Lane		4	Orleans
Jan 1998	Brookside-Bradford		4	Orange
April 1998	Sager	-3		Rutland
June 1998	Vermont Veterans Home	-1		Bennington
Dec 1998	Gifford	-53		Orange
Dec 1998	Copley	-10		Lamoille
May 2000	Copley	-10		Lamoille
June 2000	Clarks	-17		Addison
Jan 2001	Helen Porter	-13		Addison
May 2001	Gifford		20	Orange
June 2001	Linden Lodge	-117		Windham
Dec 2001	Sager	-33		Rutland
July 2002	Copley		10	Lamoille
Oct 2002	Stratton House	-18		Windham
Oct 2002	Mt Ascutney	-8		Windsor
Sept 2003	Eden Park-Brattleboro	-44		Windham
Feb 2004	Brookside-Bradford	-80		Orange
<i>Subtotal, nine years prior to CFC</i>		<i>-417 (-46/year)</i>	<i>38 (+4/year)</i>	<i>Net-42/year</i>
Oct 2005	Newport	-10		Orleans
Jan 2006	Mt. Ascutney	-8		Windsor
Sept 2006	Gifford		10	Orange
Oct 2006	Burlington Health & Rehab	-42		Chittenden
Feb 2007	Morrisville	-90		Lamoille
Aug 2007	Wake Robin		18	Chittenden
Jan 2008	Mt. Ascutney	-15		Windsor
Jan 2008	Vermont Veterans Home	-7		Bennington
<i>Subtotal, less than 3 years of CFC</i>		<i>-172 (-69/year)</i>	<i>28 (+11/year)</i>	<i>Net -58/year</i>
TOTAL		-579	66	
NET:		-513		

In an AARP survey conducted in Vermont in 2002, 93% of a random sample of AARP members said that it would be important to them to have long-term care services that would enable them, or a family member, to stay at home as long as possible (*AARP Vermont*

Member Survey: Long-Term Care, 2003). This is consistent with the core concept in Choices for Care: since people tend to prefer home and community based settings, when they are given free choice, they will tend to choose home and community- based settings.

If this is true, increased use of home and community-based services should be correlated with decreased use of nursing homes, as eligible Vermonters disproportionately choose one setting over the other. The table below shows the differences in the use of each setting in Vermont counties between October 2005 and December 2007.

**Changes in Use of NH, HCBS and ERC by County
October 2005 to December 2007**

	ERC	HCBS (exc. MNG)	NH
ADDISON	+13	+26	-5
BENNINGTON	+8	+21	-25
CALEDONIA	+1	+34	-18
CHITTENDEN	+13	+62	-45
ESSEX**	NA	+8	+2
FRANKLIN	+22	+44	+7
GRAND ISLE**	NA	+2	0
LAMOILLE	+30	+16	-60
ORANGE	+9	+3	+12
ORLEANS	+10	+75	+2
RUTLAND	+9	+67	-34
WASHINGTON	+3	+11	-2
WINDHAM	+11	+20	-11
WINDSOR	+9	+2	-17
STATEWIDE	+139	+393	-178
** no nursing homes within the county			

Using monthly Medicaid claims data for the entire period October 2005 - June 2007, Pearson product correlation coefficient values were calculated to determine the relationships between the uses of the three service options in each Vermont county. A positive value means that use of two different settings is positively correlated: both are increasing, both are decreasing, or both

are remaining stable. A negative value means that the use of two different settings is negatively correlated, i.e. one is increasing while the other is decreasing. As values approach the maximum value of 1.0, there is stronger evidence of a consistent relationship. The results are shown in the following table:

**Correlations in Changes in Use of NH, HCBS and ERC by County
October 2005 to December 2007**

		ERC	HCBS (exc. MNG)	NF bed changes
ADDISON*	HCBS	0.854	X	
	NH	-0.687	-0.637	
BENNINGTON*	HCBS	0.615	X	
	NH	-0.232	-0.517	
CALEDONIA*	HCBS	NA	X	
	NH	NA	-0.901	
CHITTENDEN*	HCBS	0.527	X	-42
	NH	-0.527	-0.890	Oct. 2006
ESSEX**	HCBS	NA	X	
	NH	NA	0.441	
FRANKLIN	HCBS	0.933	X	
	NH	0.162	0.185	
GRAND ISLE**	HCBS	X	X	
	NH	X	-0.401	
LAMOILLE*	HCBS	0.908	X	-90
	NH	-0.989	-0.895	Feb. 2007
ORANGE	HCBS	0.434	X	+10
	NH	0.771	0.510	Sep. 2006
ORLEANS	HCBS	0.953	X	-10
	NH	0.556	0.482	Oct. 2005
RUTLAND*	HCBS	0.866	X	
	NH	-0.737	-0.853	
WASHINGTON	HCBS	0.615	X	
	NH	-0.056	0.209	
WINDHAM*	HCBS	0.566	X	
	NH	-0.582	-0.580	
WINDSOR	HCBS	0.358	X	-8
	NH	-0.365	0.350	Jan. 2006
STATEWIDE*	HCBS	0.980	X	
	NH	-0.920	-0.937	
* significant negative correlation between use of NF and community based services (95% confidence level)				
** no nursing homes within the county				

Data source: EDS paid claims (claims view universe)

Increased Use of Home and Community-Based Services, Decreased Use of Nursing Homes: The use of ERC and NH was significantly negatively correlated in Addison, Chittenden, Lamoille, Rutland, and Windham Counties. In these counties, increased use of ERC was associated with a decrease in the use of NH.

The use of HCBS and NH was significantly negatively correlated in Addison, Bennington, Caledonia, Chittenden, Grand Isle, Lamoille, Rutland, and Windham Counties. In these counties, increased use of HCBS was associated with a similar decrease in the use of NH.

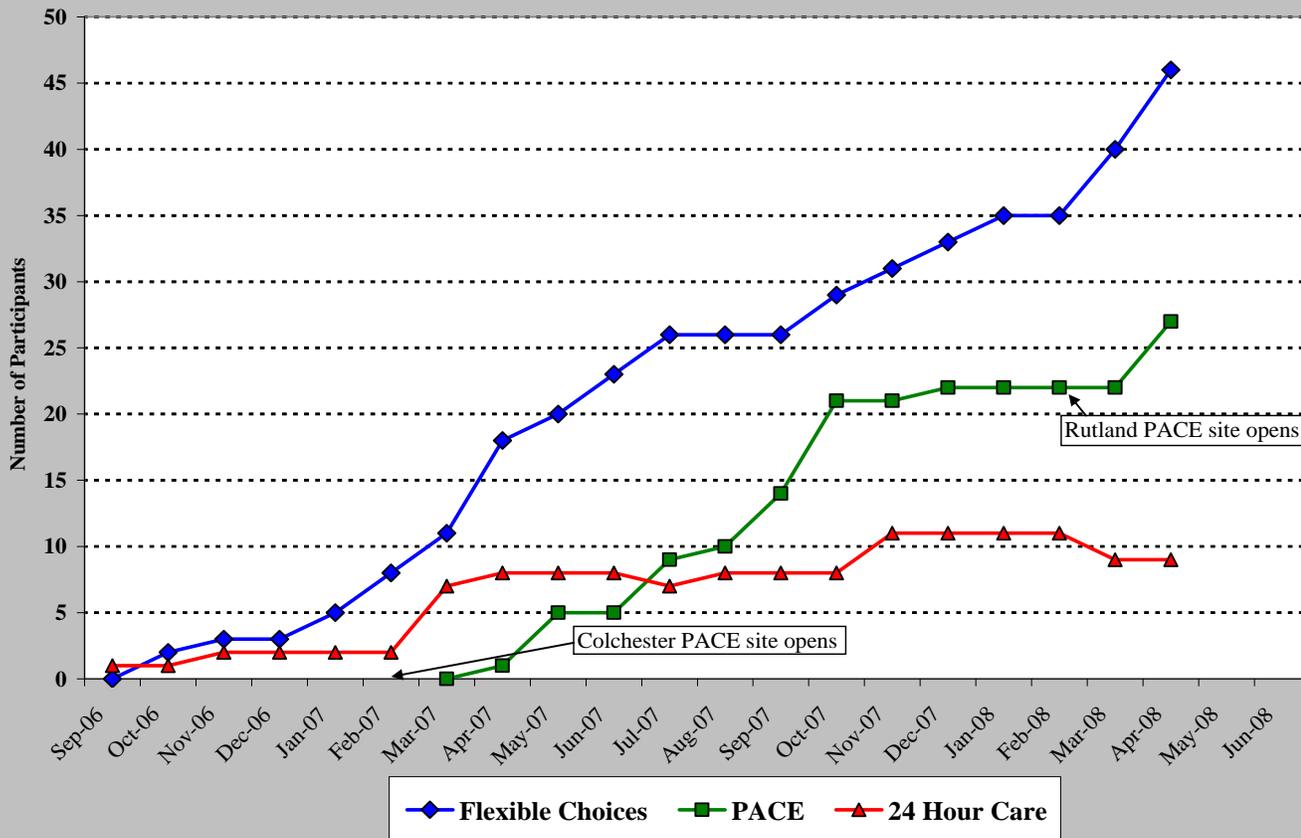
Increased Use of Home and Community-Based Services, no Decreased Use of Nursing Homes:

In Essex, Franklin, Orange, and Orleans Counties, the use of HCBS and ERC increased while the use of NF also increased. In Washington and Windsor Counties, the use of ERC or HCBS increased, but was not significantly correlated with decreased use of nursing homes.

Conclusion

There is some evidence that the increased use of home and community-based services has been associated with decreased use of nursing homes. In 8 of 14 counties, increased use of home and community-based services was significantly correlated with decreased use of nursing homes. In 3 more counties, increased use of home and community-based services was correlated with decreased use of nursing homes, but not significantly. In the remaining 4 counties, use of home and community-based services and of nursing homes both increased.

Choices for Care: Expansion of New Service Options, sfy2007-sfy2008
Flexible Choices, PACE, and HCBS 24-Hour Care
October-December 2007 data estimated

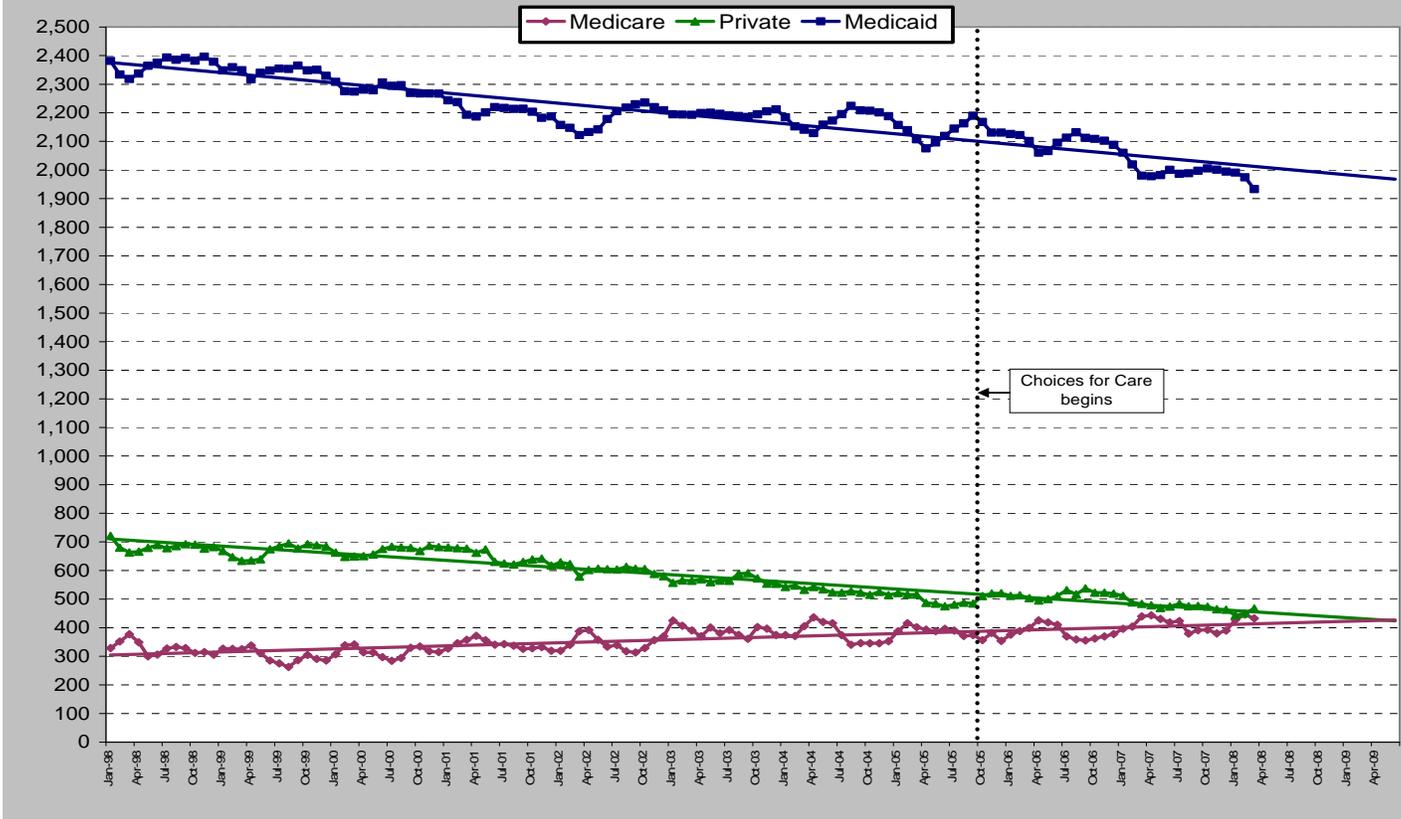


Data source: DAIL/DDAS SAMS database

One objective of Choices for Care is to expand the range of service options. This graph shows the history of enrollment in three new options: Flexible Choices, PACE, and HCBS 24-Hour Care. Each represents a different service model, drawing people with different goals and expectations. While the development of the new options represents a success, the numbers of people using these options remains modest, a very small percentage of the total number of people served in Choices for Care.

A fourth new option has also been developed under Choices for Care. Medicaid laws and regulations prohibit caregiving payments to spouses, except under extraordinary circumstances. However, this prohibition can be ‘waived’ through the 1115 Waiver, and in May 2007 Choices for Care implemented a policy allowing spouses to be paid to provide personal care. Several factors, including restrictions on household income and the presence of a spouse who is available and able to provide care, are expected to limit the number of people who choose this service option. While no method exists to track the number of spouses who are paid to provide care, Choices for Care staff plan to implement a method in the near future.

Vermont Nursing Home Bed Use: Medicaid, Medicare and Private Pay
Average Number of Residents per Day by Primary Payor Source , January 1998 - March 2008
source: DRS monthly provider census reports; excludes out of state nursing homes and swing beds



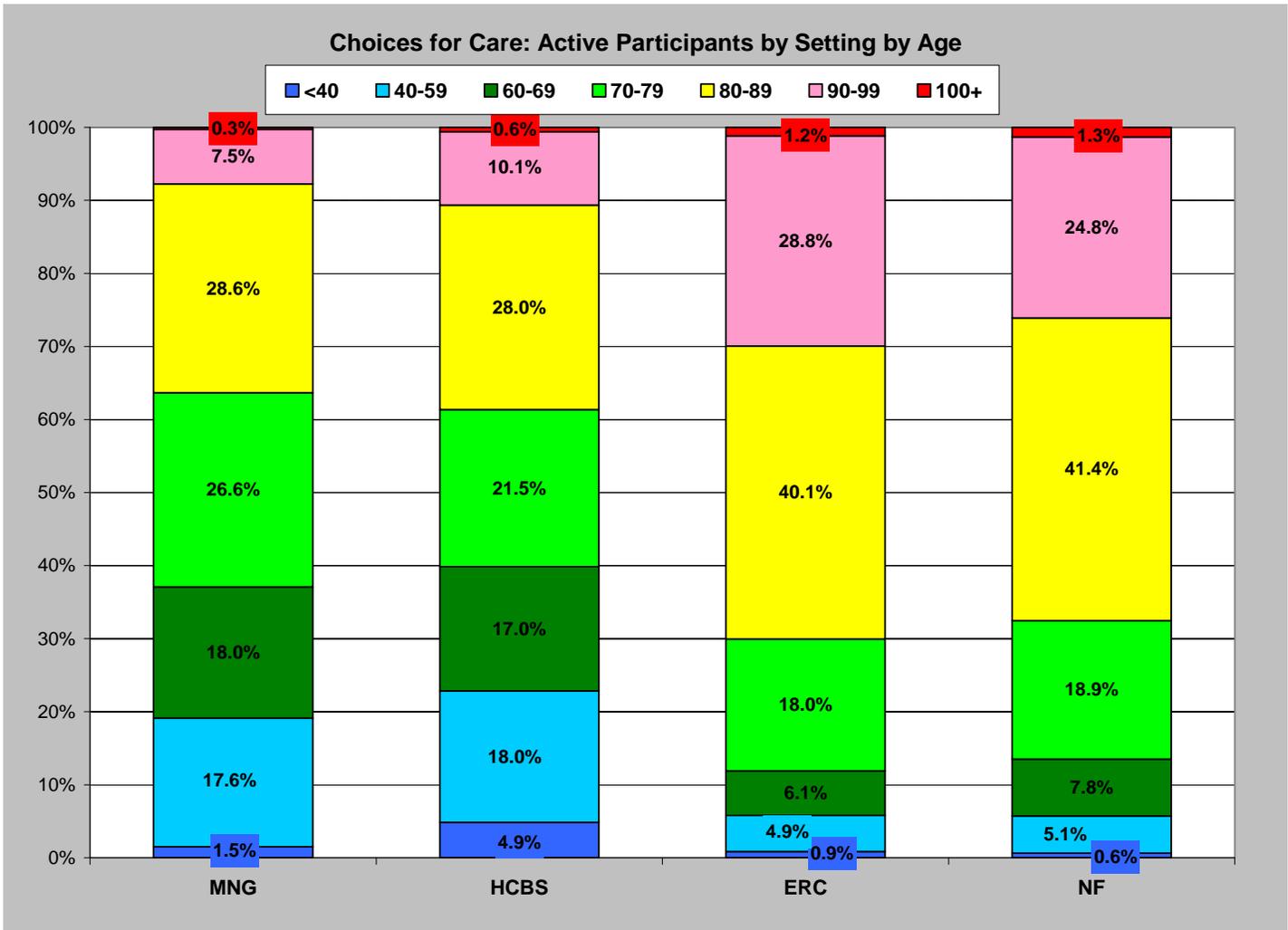
Data source: Agency of Human Services Division of Rate Setting, reported resident days by month.

This graph shows trends in the use of Vermont nursing homes for residents whose primary payment source was Medicaid, private pay, or Medicare. The average occupancy figures are derived from monthly days of service reported to the Division of Rate Setting by Vermont nursing homes.

The number of Medicaid nursing home residents decreased by 235 people between October 2005 and March 2008. Again, note that reductions in the number of licensed nursing home beds contribute to this decrease.

The number of private pay residents decreased by 45 people between October 2005 and March 2008. Long term care Medicaid financial eligibility requirements have become more rigorous in recent years, which would tend to increase the number of nursing home residents who pay privately. However, if more people are paying privately for home and community-based services, this would tend to decrease the number of nursing home residents who pay privately.

The number of Medicare residents has increased by 75 people between October 2005 and March 2008. A seasonal pattern in the number of Medicare residents appears to exist, with higher numbers in the late winter and spring. The data suggests an inverse relationship between the numbers of Medicare and Medicaid residents: as the number of Medicare residents increases, the number of Medicaid residents tends to decrease; as the number of Medicare residents decreases, the number of Medicaid residents tends to increase.



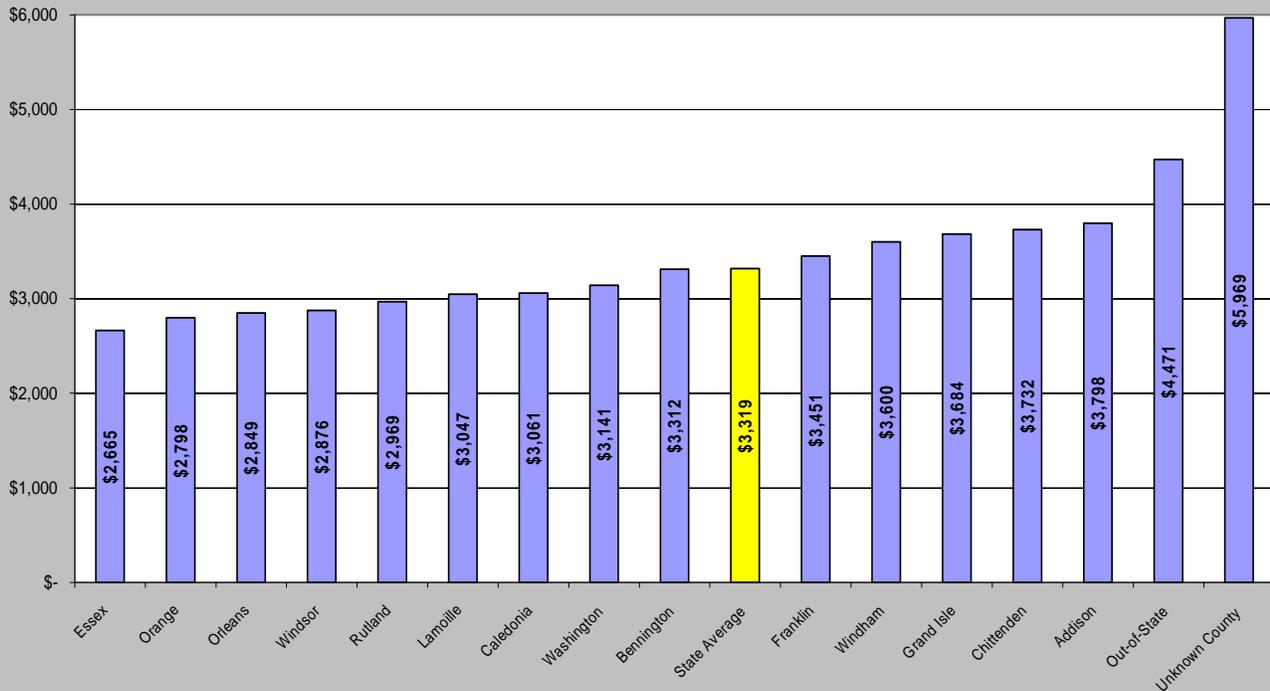
Data source: DAIL/DDAS SAMS database.

This graph shows the ages of participants in Choices for Care groups: the Moderate Needs Group, Home and Community-Based Services, Enhanced Residential Care, and Nursing Facility. (Only High Needs and Highest Needs Groups are included in the last three.)

Overall, nearly half of all Choices for Care participants were aged 80 or older, and nearly 20% aged 90 or over. The highest percentage of people aged 80 and over was in the Enhanced Residential Care setting, followed by the Nursing Facility setting. The highest percentage of people under the age of 60 was in the HCBS setting: close to 23%, representing nearly 350 people.

Choices for Care: Average Monthly Cost of Approved HCBS Plans of Care by County, April 2008

(Highest and High Needs Groups only- not all POCs adjusted for 7/1/07 rate increases)



Data source: DAIL/DDAS SAMS database.

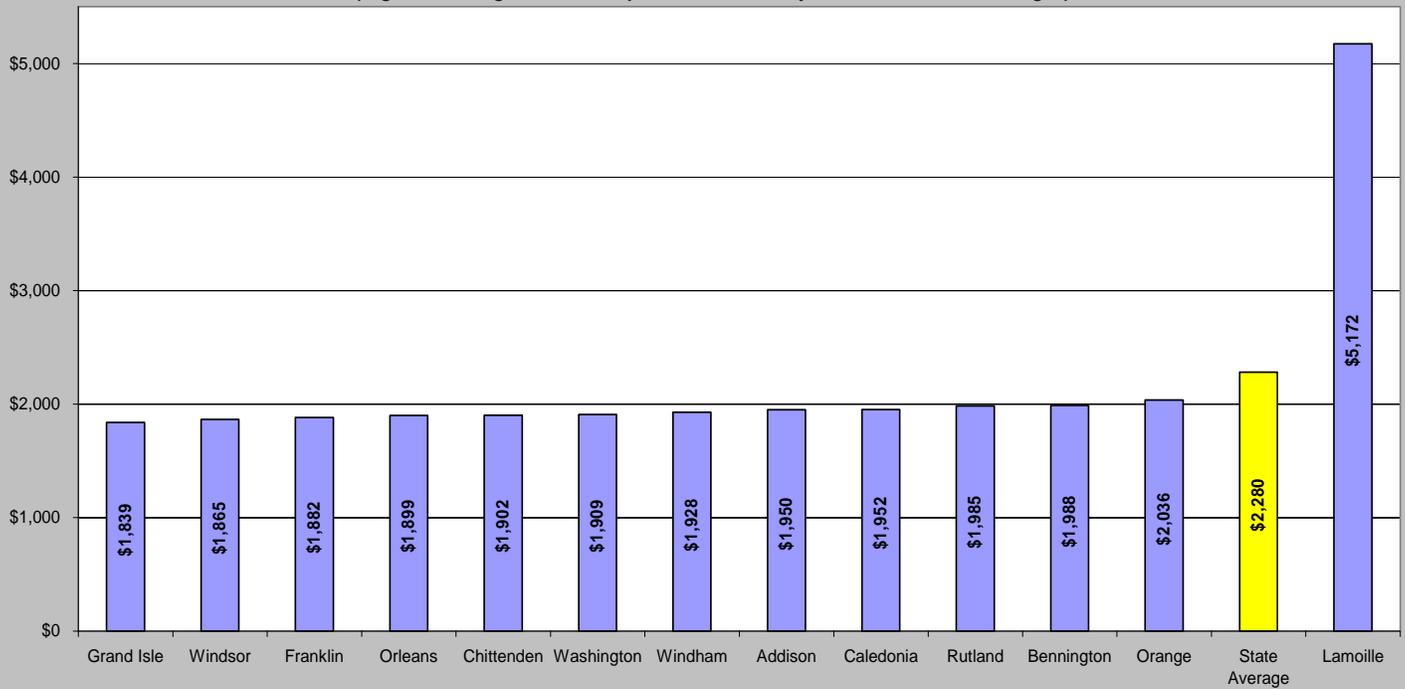
The average approved cost of HCBS Highest/High Needs Group Plans of Care was \$3,319. The average costs in Addison, Chittenden and Grand Isle Counties were well above the state average. The average cost in Essex and Orange Counties was well below the state average.

Several factors can contribute to high HCBS plan of care costs, including:

1. Lower reliance on unpaid caregiving.
2. Higher use of Home Health Agency services (rather than consumer or surrogate directed services) at higher reimbursement rates.
3. Higher authorized number of personal care service hours.
4. Higher use of adult day services.
5. Lower use of Home Health services (nursing and licensed nurse assistants) supported by Medicare or Medicaid, with Choices for Care services substituted.

Choices for Care: Average Cost of Approved ERC Plans of Care by County, as of April 2008

(Highest and High Needs Groups- not all POCs adjusted for 7/1/07 rate changes)



Data source: DAIL/DDAS SAMS database.

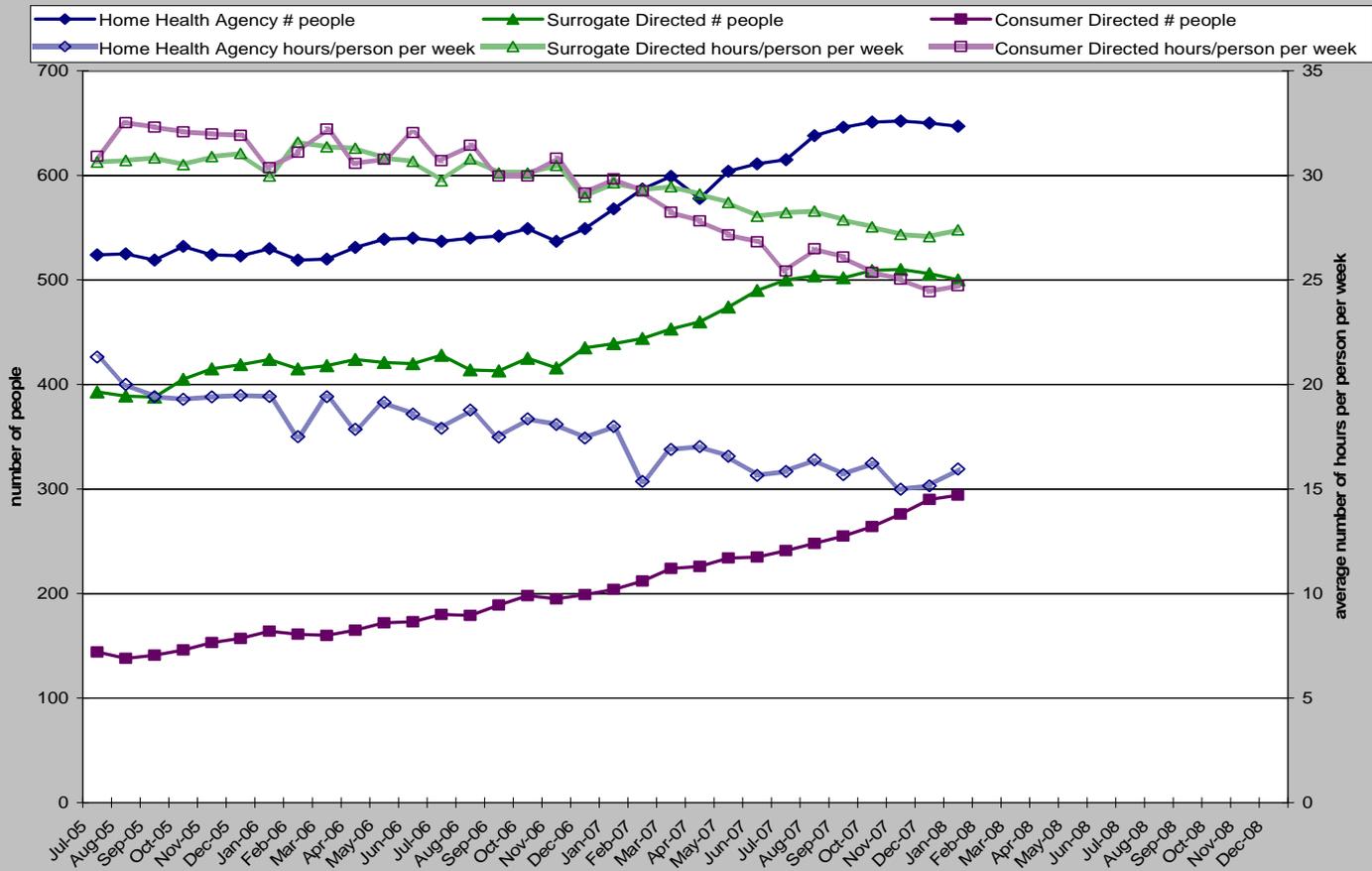
The average approved cost of ERC Highest/High Needs Group plans of care was \$2,280, nearly 40% less than the average approved cost of home-based plans of care.

With the exception of “special rates”, the range of ERC plan of care costs is smaller because fewer factors contribute to the differences. ERC plans of care represent three daily reimbursement “tiers” based on the functional and cognitive status of ERC participants, rather than a specific number of hours of personal care. ERC plans of care do not include adult day services, which can contribute to higher home-based plan of care costs.

The highest costs were found in Lamoille County. This is caused by special rates paid to Lamoille County providers to serve people who were discharged from Morrisville Center nursing home when it closed, and to support other people who transitioned from Traumatic Brain Injury services to ERC services.

There appears to be no consistent relationship between approved home-based costs and approved ERC costs by county.

Choices for Care Personal Care Service Hours by Type, sfy2005 - sfy2008



Data source: EDS paid claims, by date of service

This graph shows recent trends in paid Medicaid claims for the three Choices for Care personal care service options: home health agency, consumer-directed, and surrogate-directed.

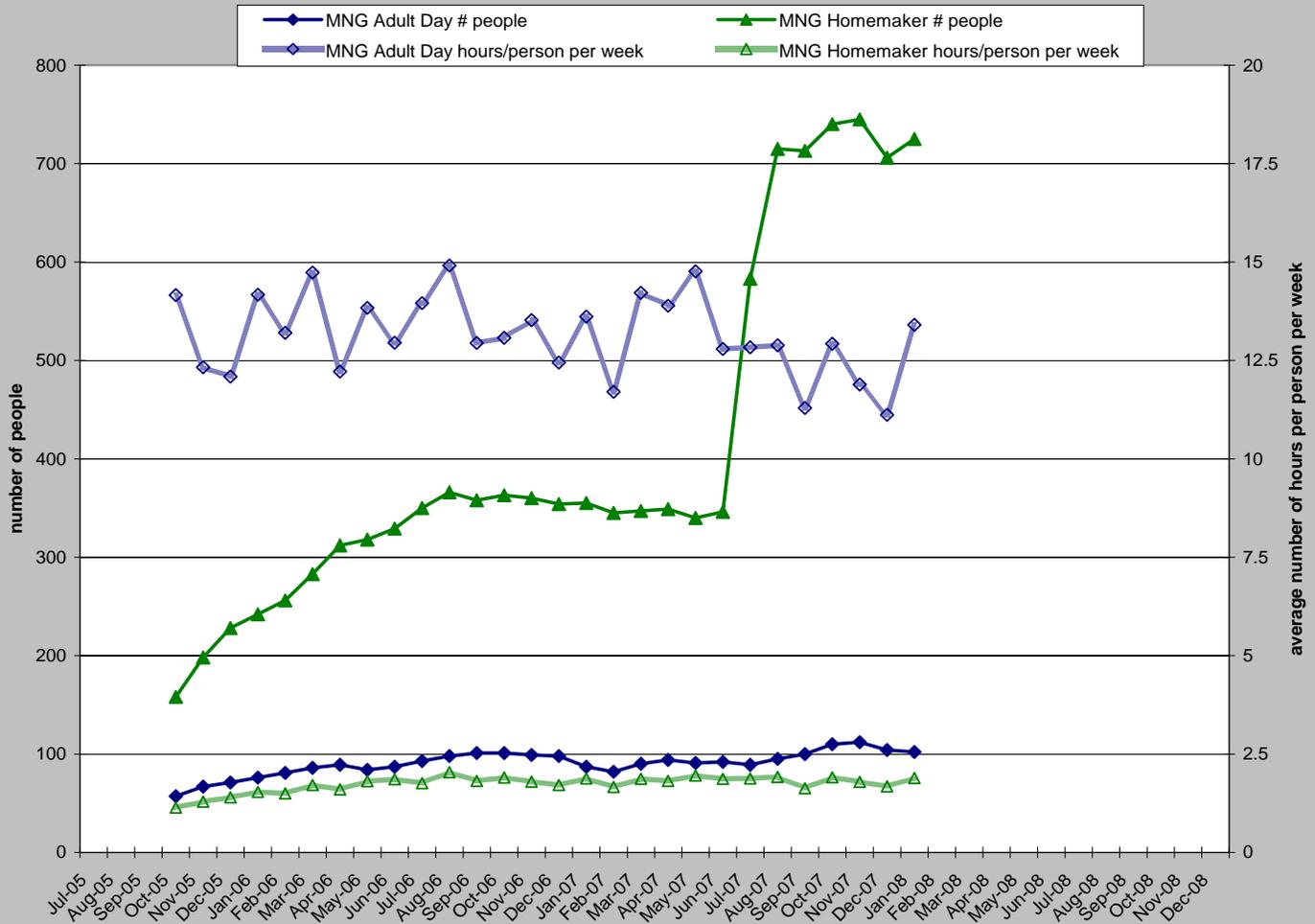
The number of people using each type of personal care services has increased significantly. The number of people using consumer-directed services has increased at the fastest rate. The numbers of people using home health services and surrogate-directed services have increased at a slower, similar rate.

The average number of service hours that people receive under each option has decreased over the past three years. There are significant differences in the average number of hours of service received through each service option:

<i>option</i>	<i>% of people</i>	<i>% of services</i>	<i>difference</i>	<i>Avg. hours per week (sfy2008 ytd)</i>
Home Health	48%	33%	-15%	16
Consumer directed	22%	23%	1%	25
Surrogate directed	37%	44%	7%	28

Because some people use a combination of these services, the total number of hours that they receive is higher.

Moderate Needs Group Services by Type, sfy2005 - sfy2008



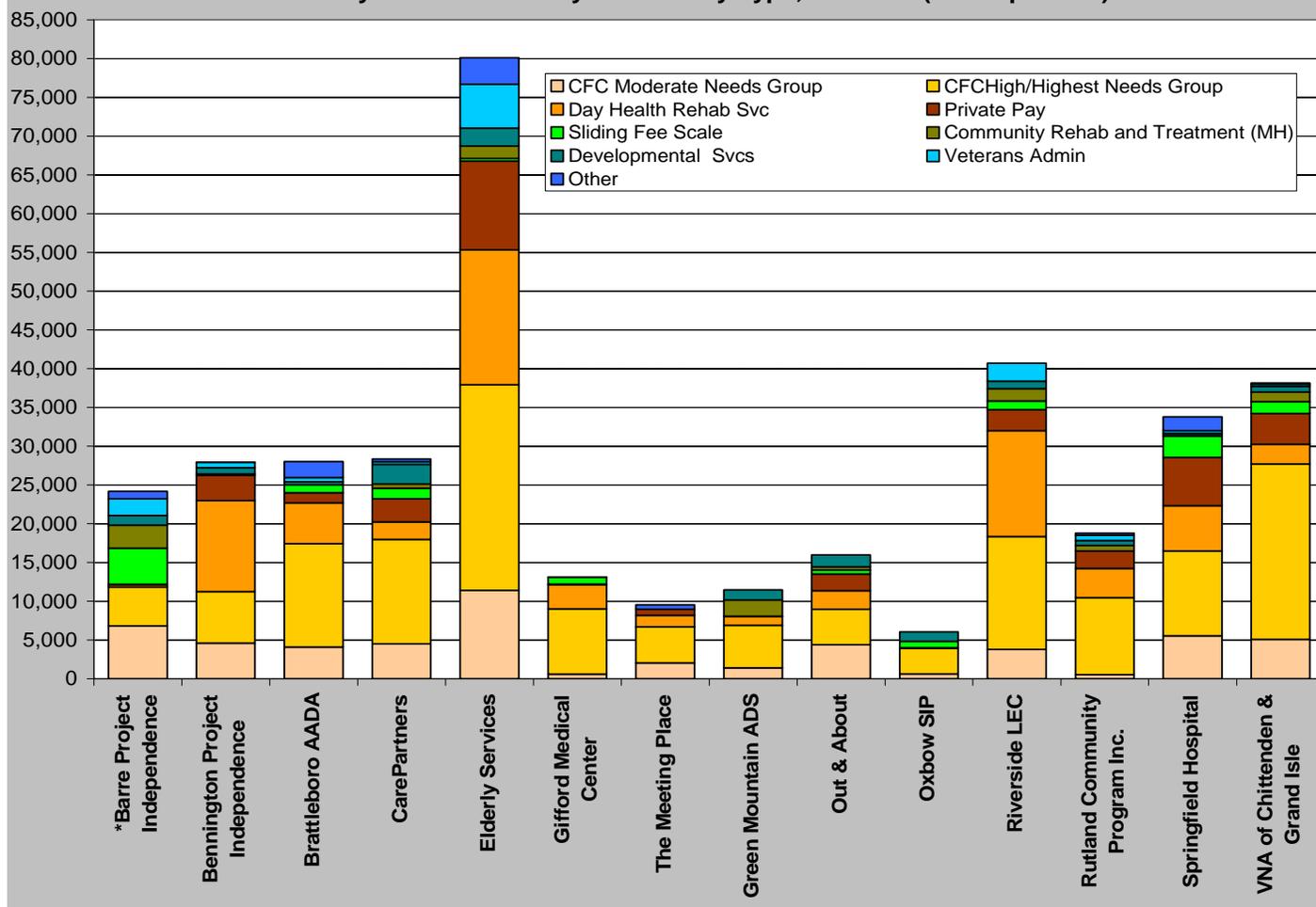
Data source: EDS paid claims, by date of service

This graph shows the use of the core Moderate Needs Group services: Adult Day and Homemaker services.

The number of MNG participants using Adult Day grew steadily from October 2005 through August 2006, and has remained near 100 people per month since then. The average number of service hours has decreased slightly, averaging about 13 hours per week per person in the last year.

The number of MNG participants using Homemaker grew steadily from October 2005 through August 2006. The number of people served each month then decreased slowly from August 2006 until July 2007, when an influx of new funding caused a rapid increase in the number of people served. The average number of service hours has averaged a bit less than 2 hours per week per person in the last year.

Adult Day Service Hours by Provider by Type, SFY2008 (three quarters)



Data source: Adult Day provider reports

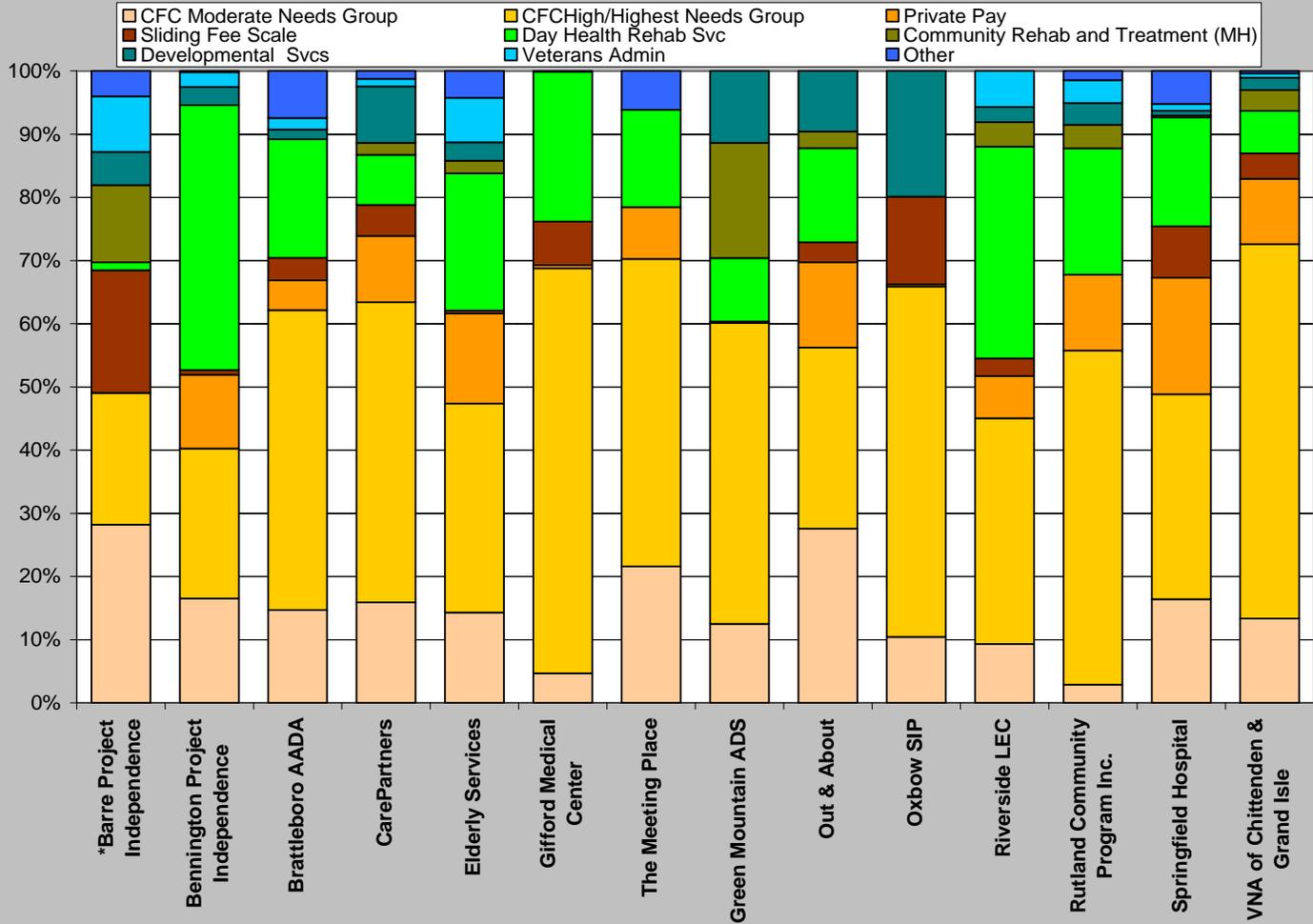
This shows the hours of services provided by Vermont’s adult day service providers, by funding source. The graph shows large differences between providers in the hours of service provided.

The total number of service hours is reflected by the height of each bar in the graph. The different heights suggest that there are four ‘sizes’ of adult day providers in Vermont:

- 1 ‘large’ provider: Elderly Services
- 7 ‘medium’ providers: Barre, Bennington, Brattleboro, CarePartners, Riverside, Springfield, VNA of Chittenden and Grand Isle Counties
- 5 ‘small’ providers: Gifford, The Meeting Place, Green Mountain, Out and About, Rutland
- 1 ‘very small’ provider: Oxbow

As the largest provider, Elderly Services reported an average of more than 2000 hours per week. Elderly Services provides about 21% of all service hours, 31% of all private pay hours, 44% of all Veterans Administration hours, and 21% of all MNG hours. As the smallest provider, Oxbow reported an average of about 155 hours per week – roughly 8% of Elderly Services’ hours.

Adult Day Service Hours by Provider by Type, SFY2008 (three quarters)

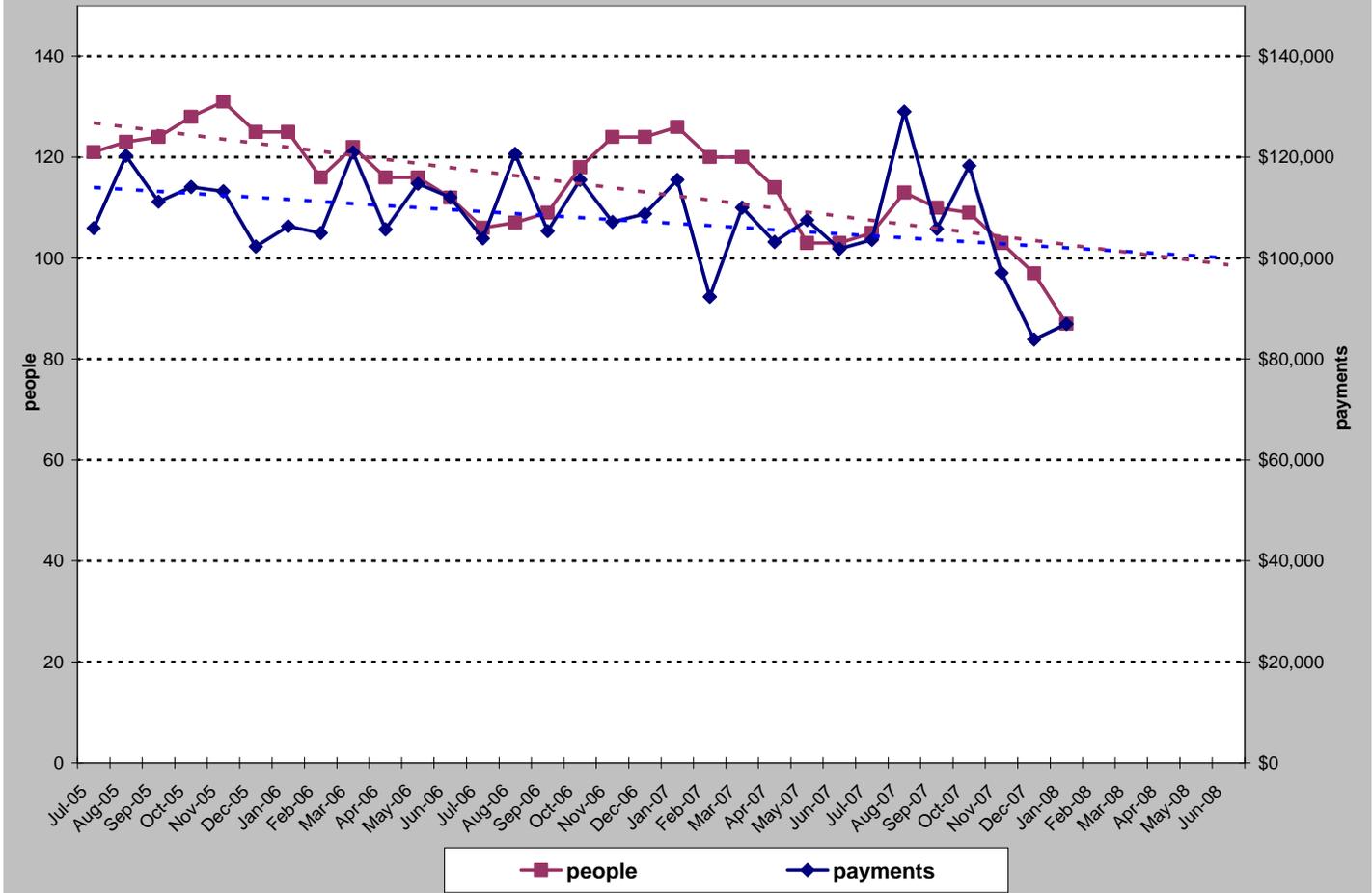


Data source: Adult Day provider reports

This shows the percentage of each provider's services that were supported by each funding source.

More than 70% of the service hours provided by The Meeting Place and the VNA of Chittenden and Grand Isle Counties were supported by Choices for Care. More than 80% of the service hours provided by Bennington Project Independence, Brattleboro Area Adult Day, Gifford Medical Center, and The Meeting Place were supported by a combination of Choices for Care and Day Health Rehabilitation Services.

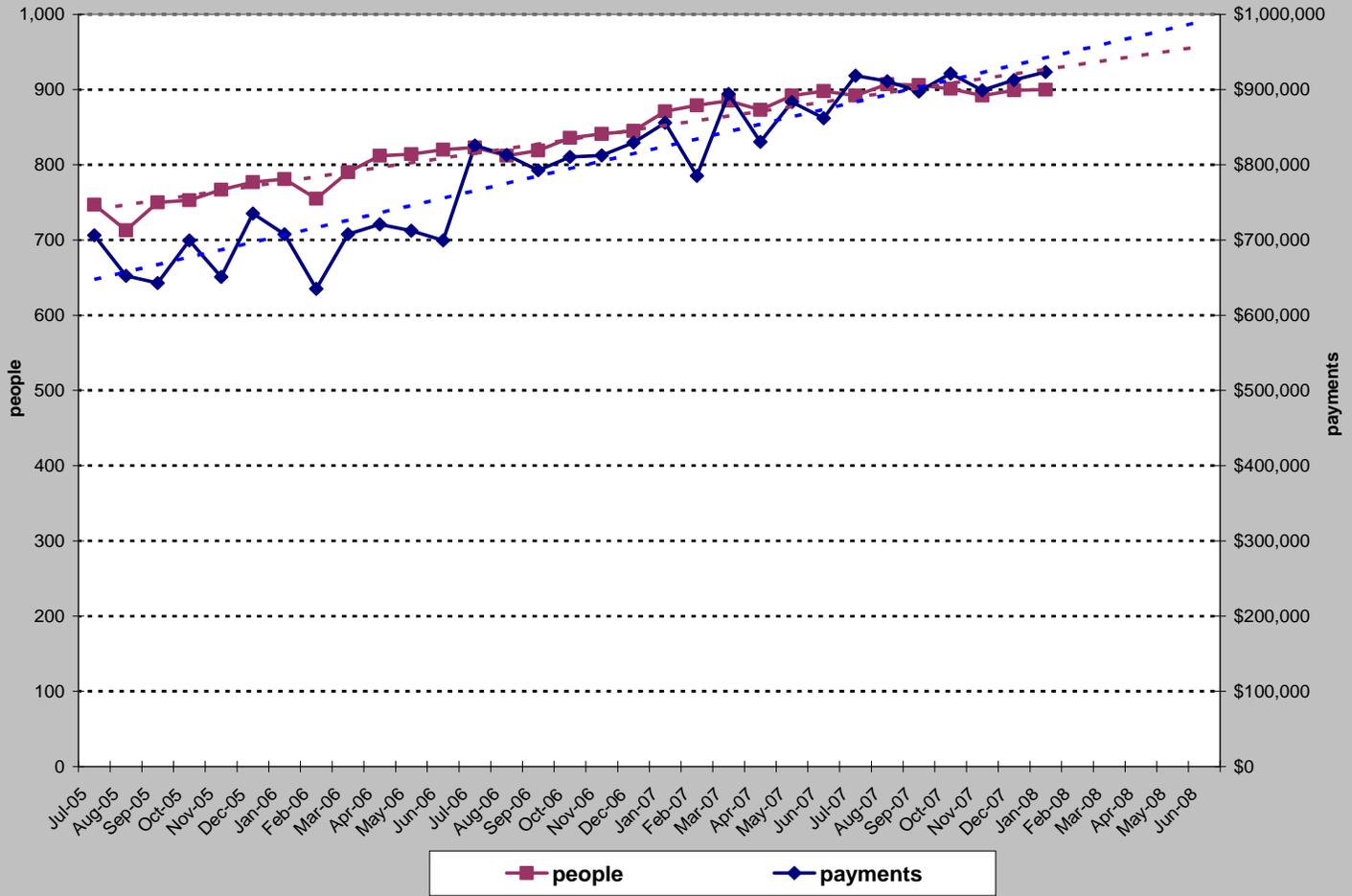
Day Health Rehabilitation Services: People and Payments, sfy2005 - sfy2008



Data source: EDS paid claims, by date of service

Day Health Rehabilitation Services (DHRS) is the community Medicaid funding source for adult day services, separate from long-term care Medicaid in Choices for Care. This shows the number of people receiving Day Health Rehabilitation Services each month and the payments for these services. The data shows an ongoing decrease in the number of people served. It is possible that some of these people are now supported by other funding sources, including Choices for Care.

Assistive Community Care Services: People and Payments, sfy2005 - sfy2008



Data source: EDS paid claims, by date of service

Assistive Community Care Services (ACCS) is the community Medicaid funding source that supports services provided by level three residential care homes. Choices for Care participants in the ERC setting are supported by a combination of ACCS payments and Choices for Care ERC payments.

This shows the number of people receiving ACCS each month, and the payments for these services. The total number of people served each month increased by more than 150 (about 20%) in less than three years.