



# **Choices for Care**

## **Quarterly Data Report**

### **July 2007**

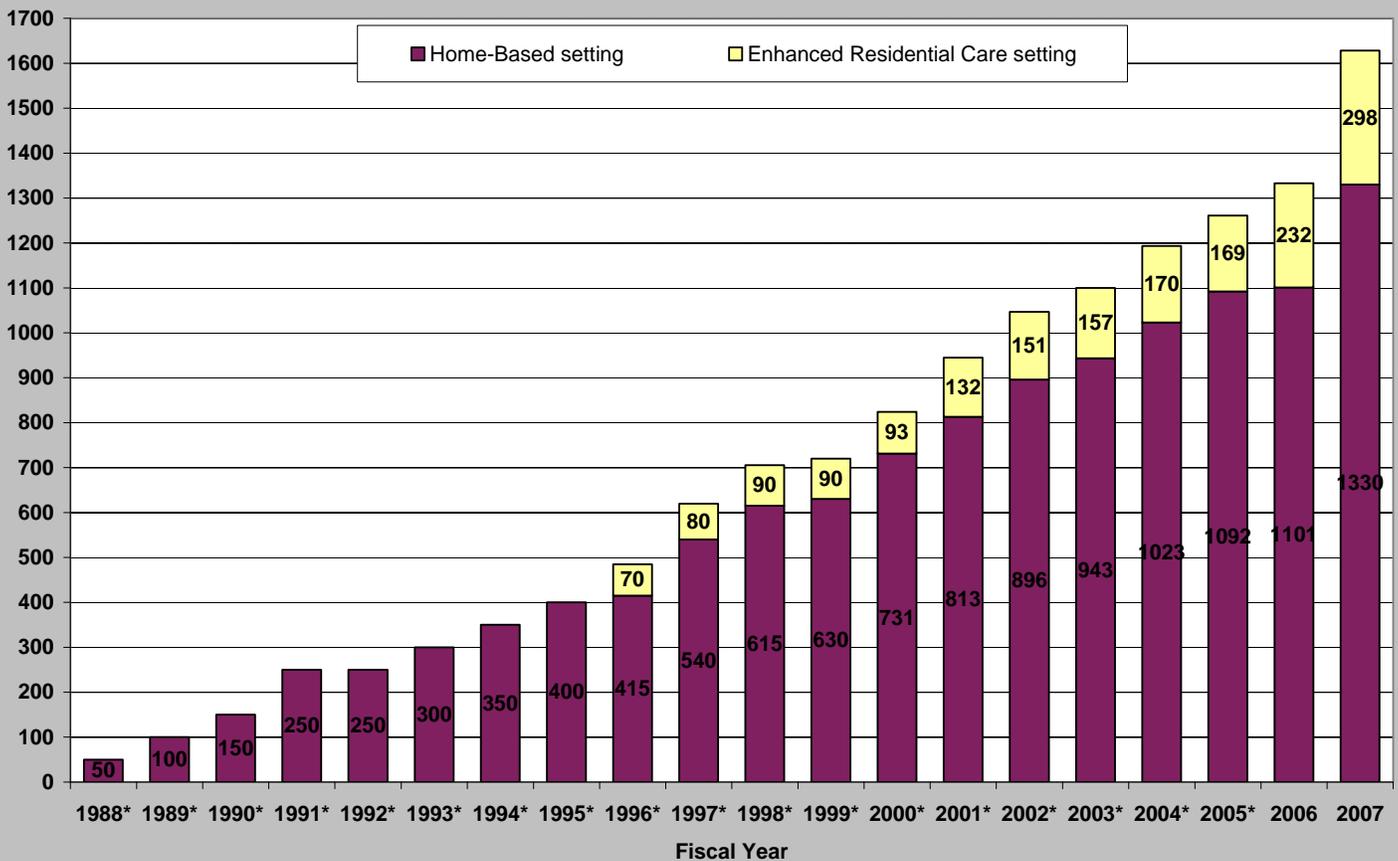
**This report documents the status and progress of Choices for Care, Vermont's long term care service system. This report is intended to provide useful information regarding enrollment, service, and expenditure trends in Choices for Care. A brief explanation accompanies each graph, chart or table.**

**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 nursing home census data from the Division of Ratesetting.**

**We welcome your comments, questions and suggestions.**

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**Numbers of People Served in Aged/Disabled Medicaid Waivers  
Maximum Number by Year, sfy1988-sfy2007**  
*(does not include moderate needs group)*



Data source: DAIL/DDAS databases

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

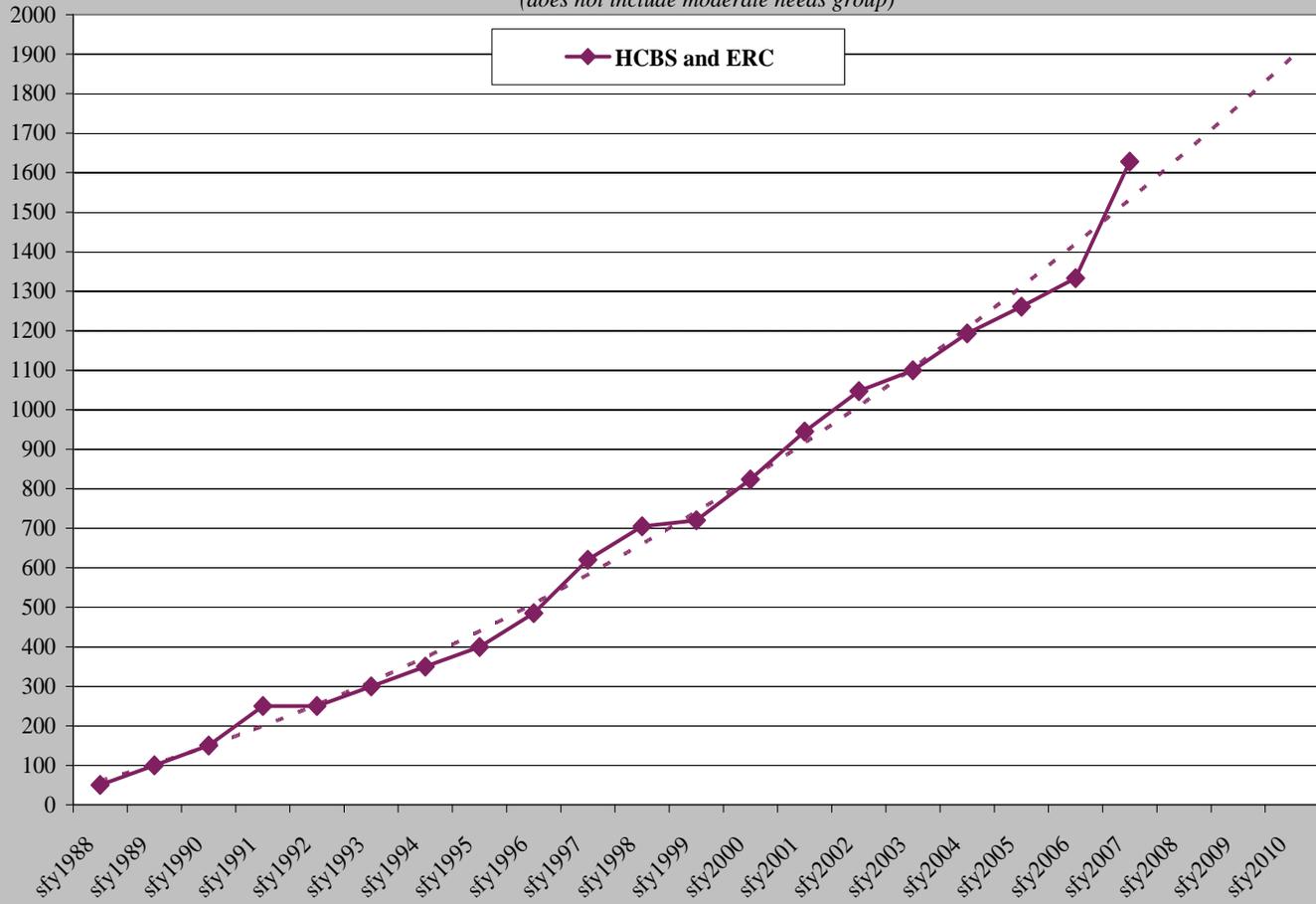
This graph illustrates the growth in home and community based services in Vermont for people over age 60 and people with physical disabilities since sfy1988.

Prior to the implementation of Choices for Care in sfy2006, growth was fairly steady, but limited by the funding available within each state fiscal year. During these years all eligible Vermonters were entitled to receive nursing home care under Medicaid, but were not entitled to receive alternative community-based long term care services. Some people who applied for home and community based services were placed on waiting lists, and had to wait for funding to become available.

In sfy2007, the number of people enrolled in home and community based settings increased by nearly 300, the largest increase ever. This represents an increase of more than 20% over the previous year.

## Numbers of People Served in Aging/Disabled Medicaid Waivers Maximum Number by Year, sfy1988-sfy2007

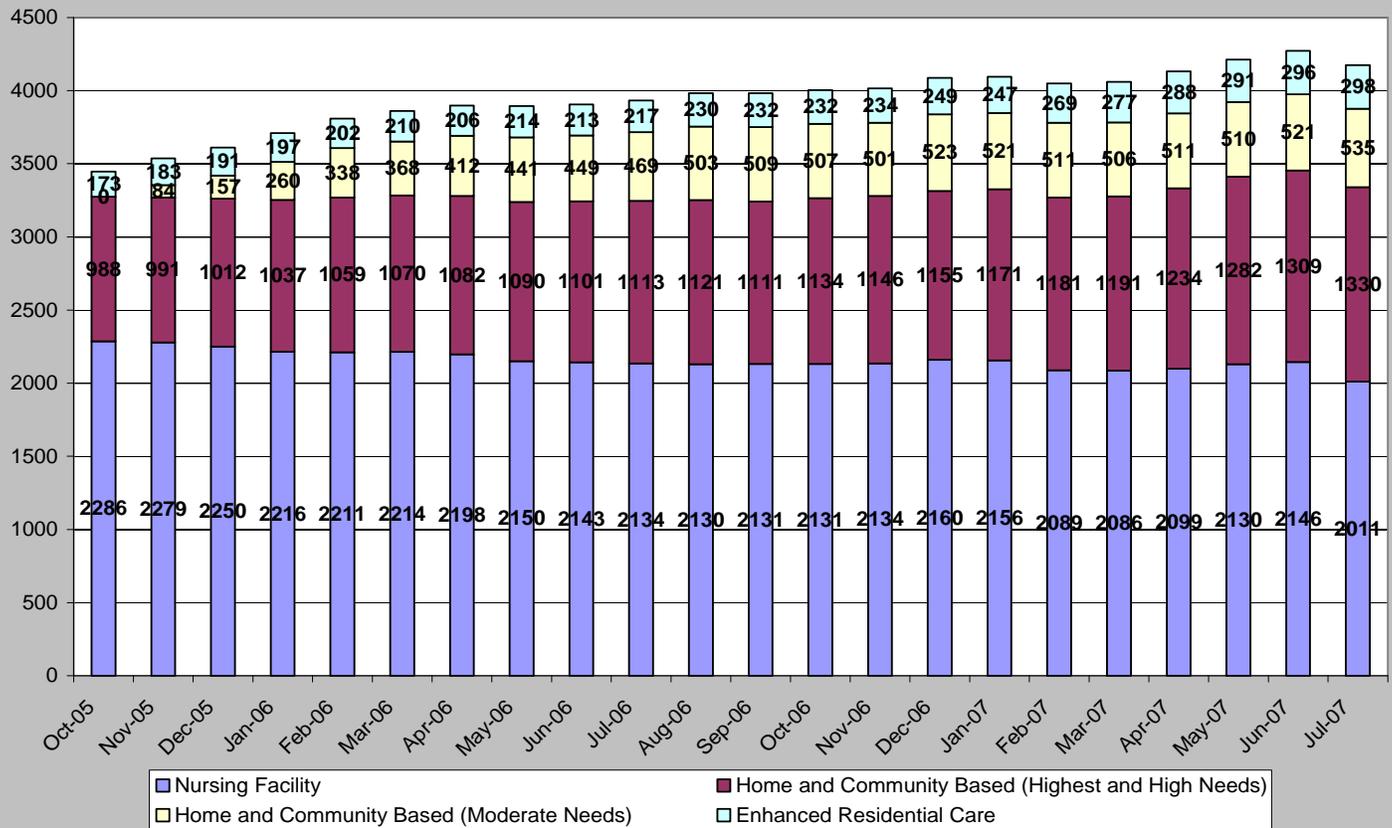
(does not include moderate needs group)



Data source: DAIL/DDAS databases

This graph combines HCBS and ERC enrollment data, and projects the historical enrollment trend through sfy2010.

## Choices for Care: Total Number of Enrolled Participants October 2005 - July 2007

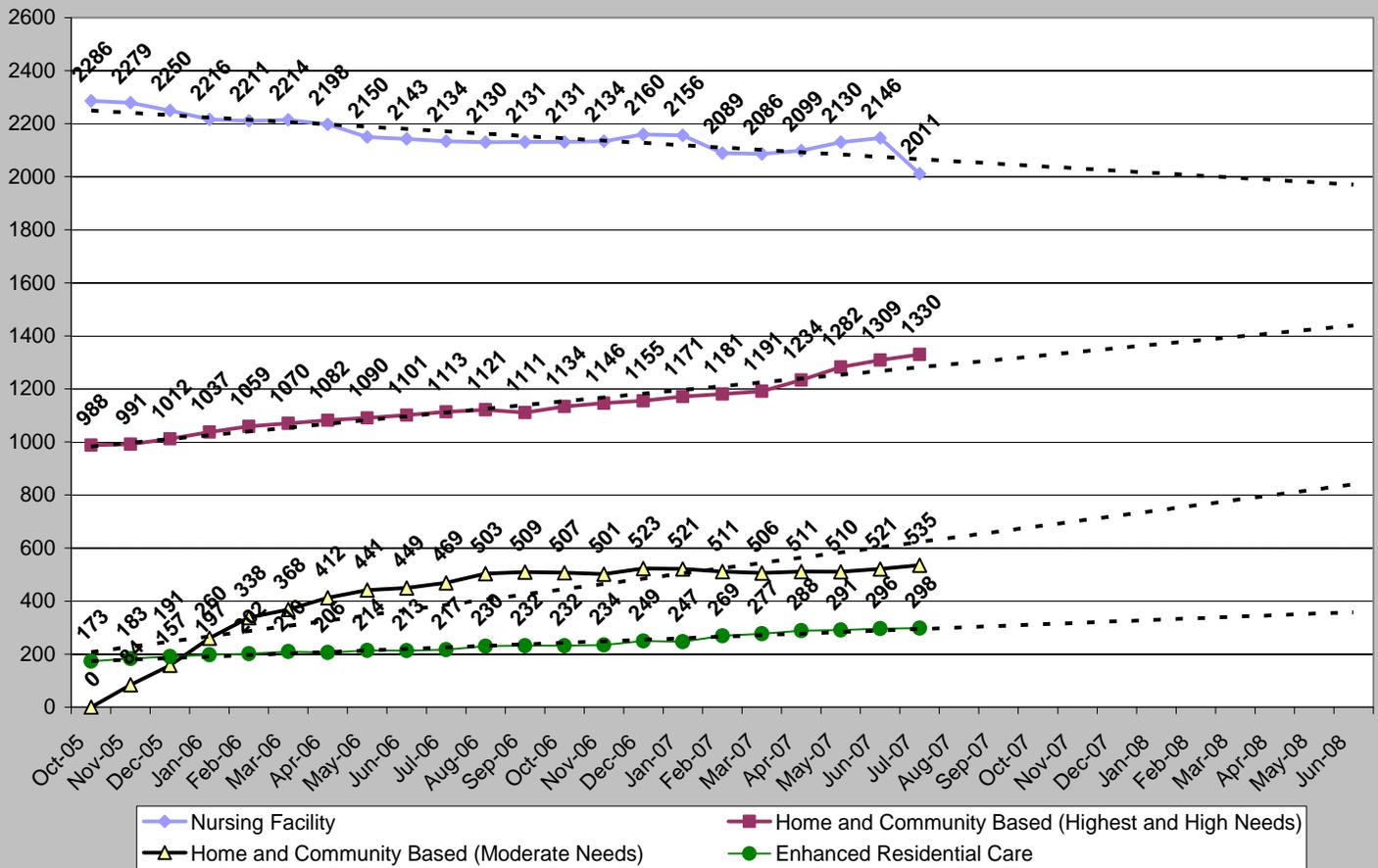


Data source: DAIL/DDAS SAMS database.

This shows the changes in enrollment in Choices for Care settings since October 2005. The number of people served in nursing homes has continued to decrease, while the numbers of people served in the Home and Community Based and Enhanced Residential Care settings have continued to increase:

1. Nursing homes: the number of people in nursing homes decreased by 275 (from 2,286 to 2,011) between October 2005 and July 2007. The closing of the Morrisville Center nursing home in January 2007 contributed to this decrease.
2. Home and Community Based Services (Highest/High Needs Groups): the number of people increased by 342 (from 988 to 1,330) between October 2005 and July 2007. Substantial increases have occurred in the last four months.
3. Enhanced Residential Care: the number of people increased by 125 (from 173 to 298) between October 2005 and July 2007. Some people transitioned to ERC settings from the TBI Waiver and from the Morrisville Center nursing home, contributing to this increase.
4. HCBS Moderate Needs Group: the number of people in this 'expansion' group increased from 0 to 535 between October 2005 and July 2007.

## Choices for Care: Total Number of Enrolled Participants October 2005 - July 2007

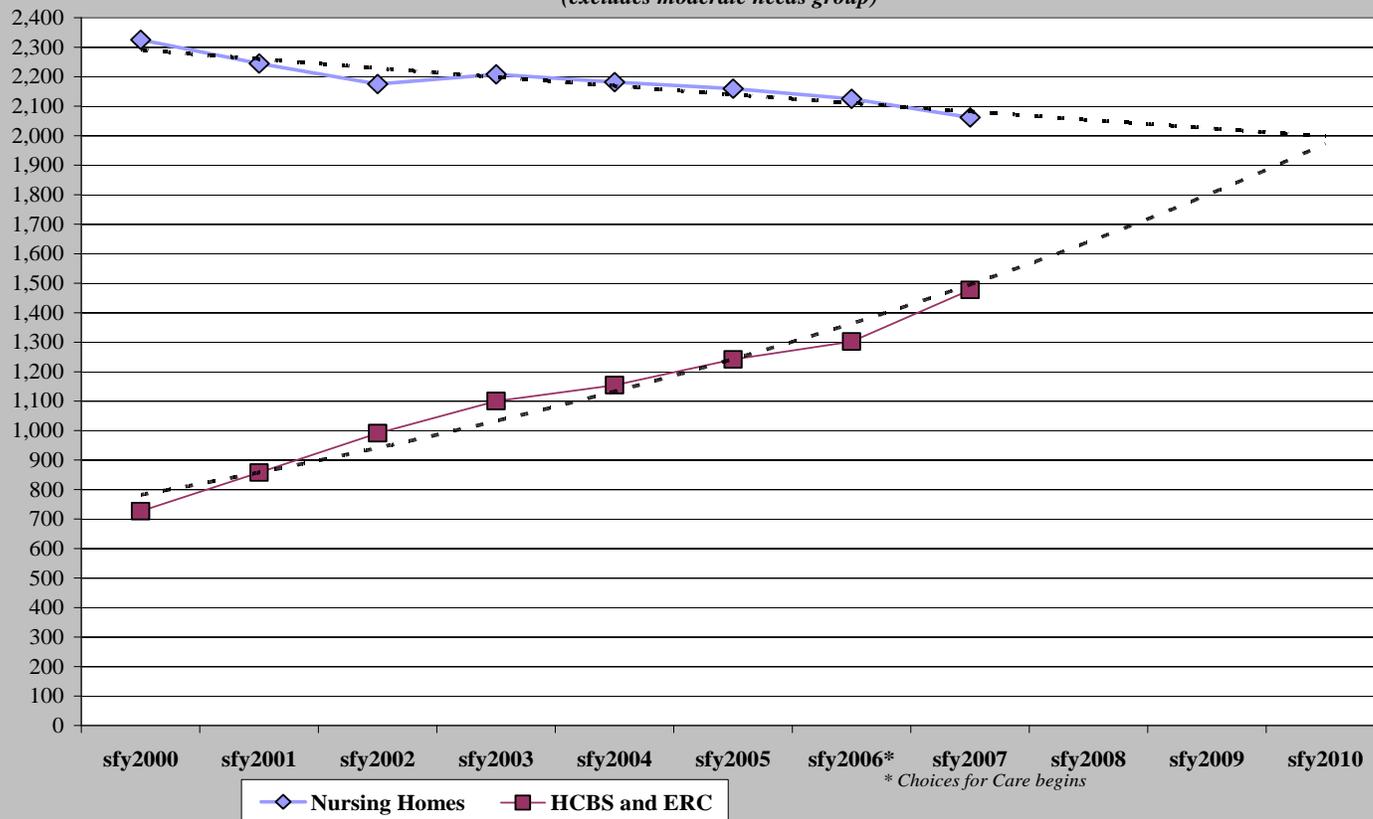


Data sources: DAIL/DDAS SAMS database

This shows another view of Choices for Care enrollment since October 2005, with projections through sfy2008.

The number of people enrolled in the HCBS and ERC settings has increased by about 450, while the number of people enrolled in nursing home settings has decreased by about 250. The core hypothesis of Choices for Care appears to be supported: by offering an entitlement to community-based care, the number of people choosing community alternatives will increase, and the number of people choosing nursing homes will decrease...and that this will make funds available to serve more people in the community.

**Vermont LTC Services: Average Number of People Served by Setting**  
**sfy2000-sfy2007**  
*(excludes moderate needs group)*

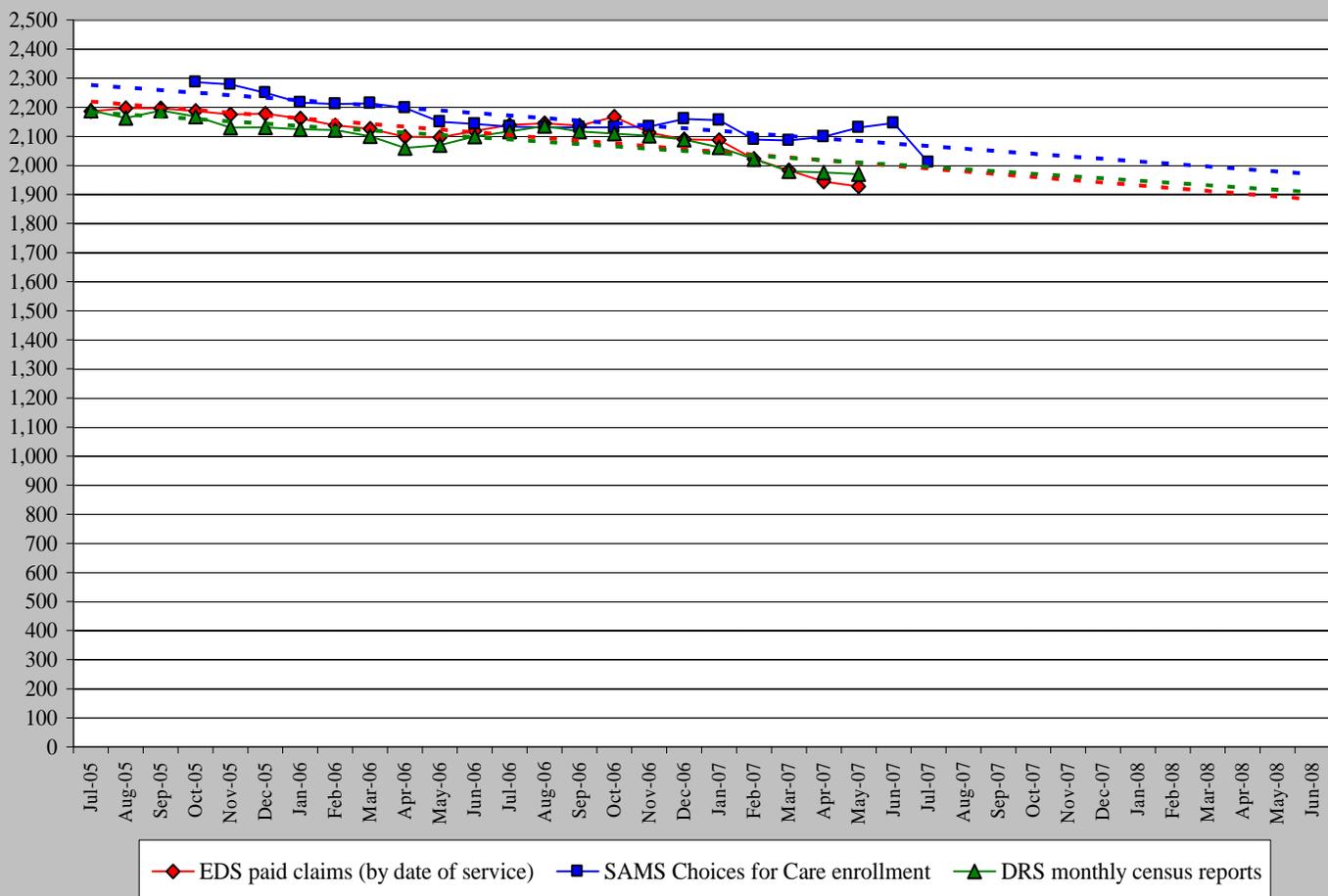


Data sources: DAIL/DDAS enrollment data; DAIL Monthly Monitoring Report; Division of Ratesetting

This graph compares trends in service settings since sfy2000, using a second data source for nursing home services (‘days’ reports submitted by nursing homes to the Division of Ratesetting).

The trends suggest that the number of people served in nursing homes will continue to decrease, and that the number of people served in alternative settings will continue to increase. If these trends continue, within three years the number of people served in alternative settings will be comparable to the number of people served in nursing homes.

### Vermont Long Term Care Medicaid: Average Number of Nursing Home Residents by Month, sfy06-sfy07 (all data sources)



Data sources: DAIL/DDAS SAMS database; EDS paid claims, by date of service; Division of Rate Setting.

This shows trends in the use of nursing homes under Medicaid using three different data sources:

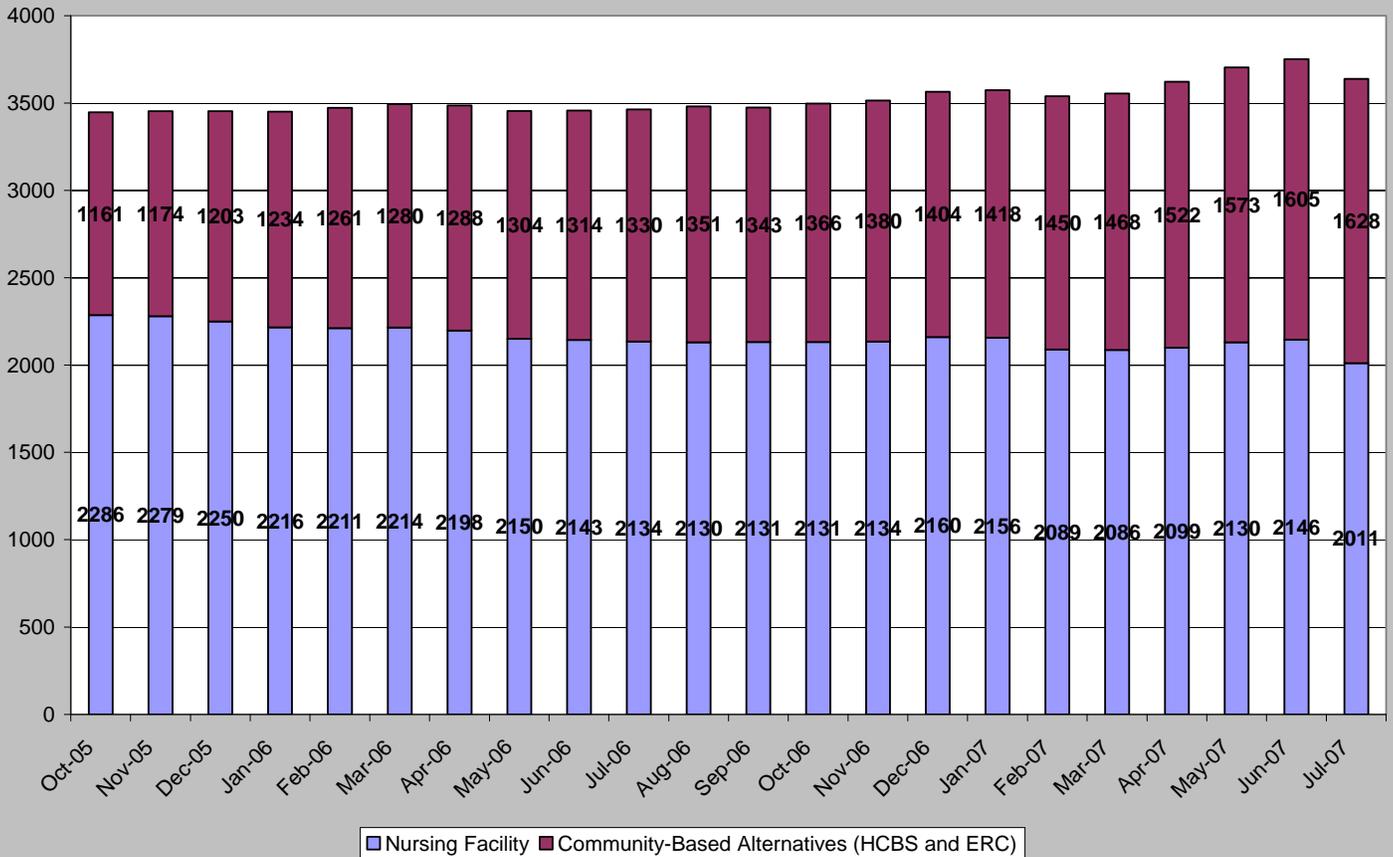
1. EDS Medicaid paid claims. This represents services actually paid by Medicaid. This is the ‘gold standard’ of Medicaid service data, but is not acceptably accurate for 3-9 months after the date of service.
2. SAMS enrollment: This enrollment data is maintained by DAIL, and is used to track applications and eligibility.
3. Division of Ratesetting monthly census reports: This monthly ‘days of service’ data is submitted by nursing homes to the Division of Ratesetting (DRS), and includes all funding sources.

All three data sources show a nearly identical trend in the declining use of nursing homes. This increases confidence in the validity of the trend. On average, the DRS data is within 1% of the EDS paid claims data (ranging from 0.1% to 2.2%). On average, SAMS data is within 3% of the EDS paid claims data (ranging from 0.3% to 7.9%).

## Choices for Care: Total Number of Enrolled Participants

October 2005 - July 2007

(excludes moderate needs group)

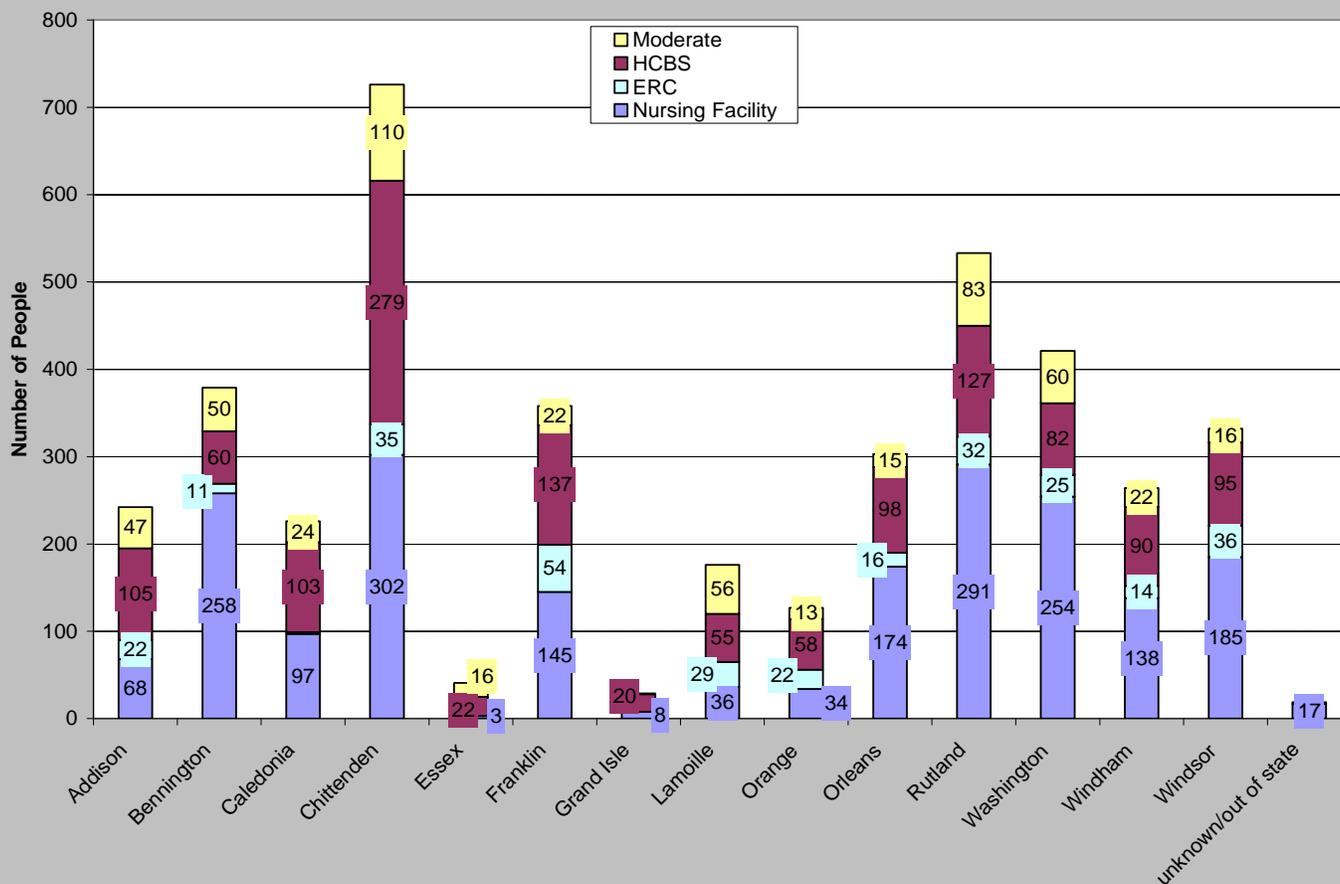


Data source: DAIL/DDAS SAMS database.

This shows trends in enrollment of people in the Highest Needs Group and the High Needs Group. All of these people meet traditional nursing home eligibility criteria.

The total number of people enrolled in these two groups has grown modestly. In 22 months, the total number enrolled has increased by about 190 people (about 3% per year). Prior to Choices for Care, the annual increase in the number of people enrolled in HCBS and ERC was also about 100. This suggests that initial concerns about a ‘woodwork effect’- in which large numbers of people would enroll in Medicaid long term care services and cause unexpected increases in the total number served, and in total costs- were unfounded.

### Choices for Care: Enrolled Participants by Setting by County as of July 2007



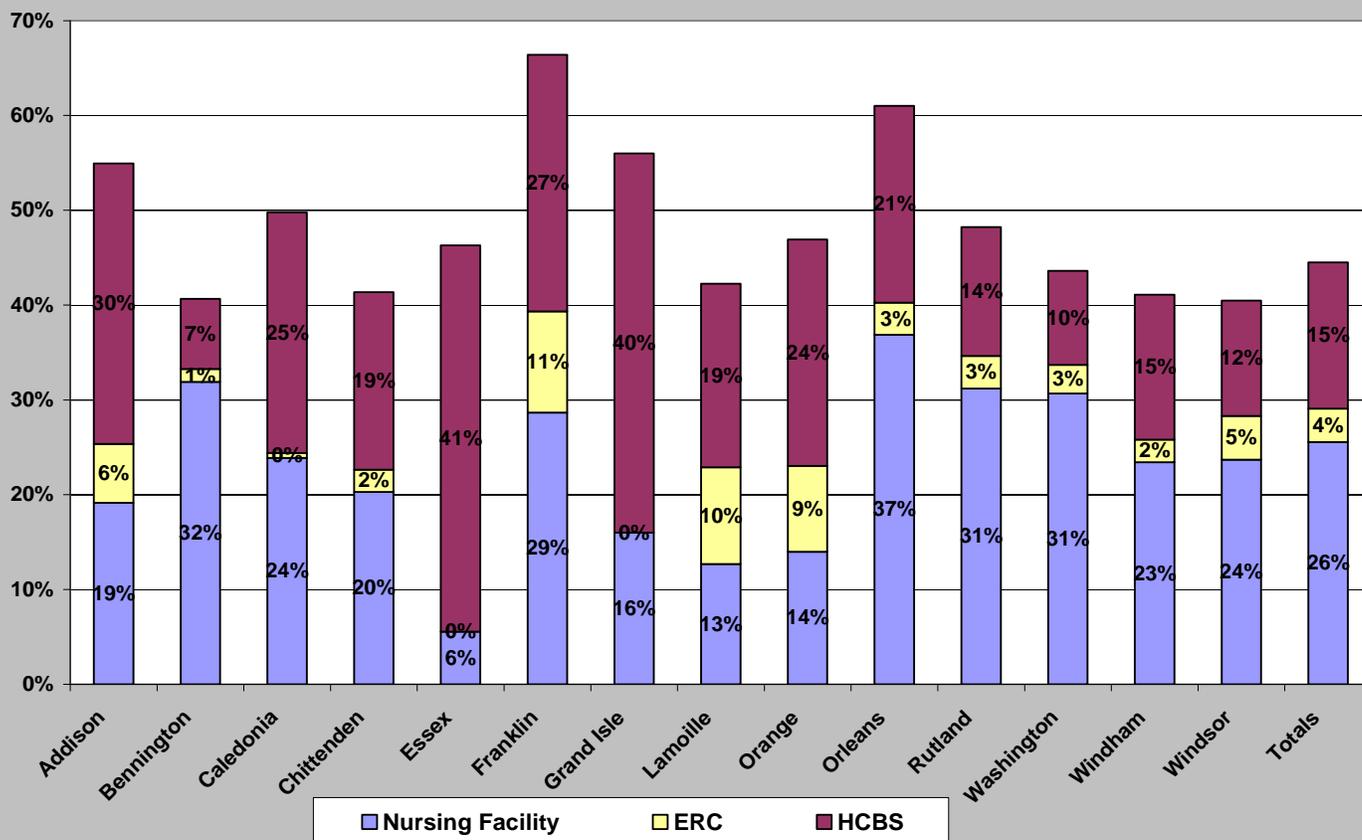
Data source: DAIL/DDAS SAMS database.

This 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, Rutland, and Washington Counties, a relatively large proportion of people in the Highest and High Needs Groups are served in Nursing Facilities.

**Choices for Care: People Served in LTC by Setting as a Percentage of Total Need  
by County - July, 2007**  
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 2007*.

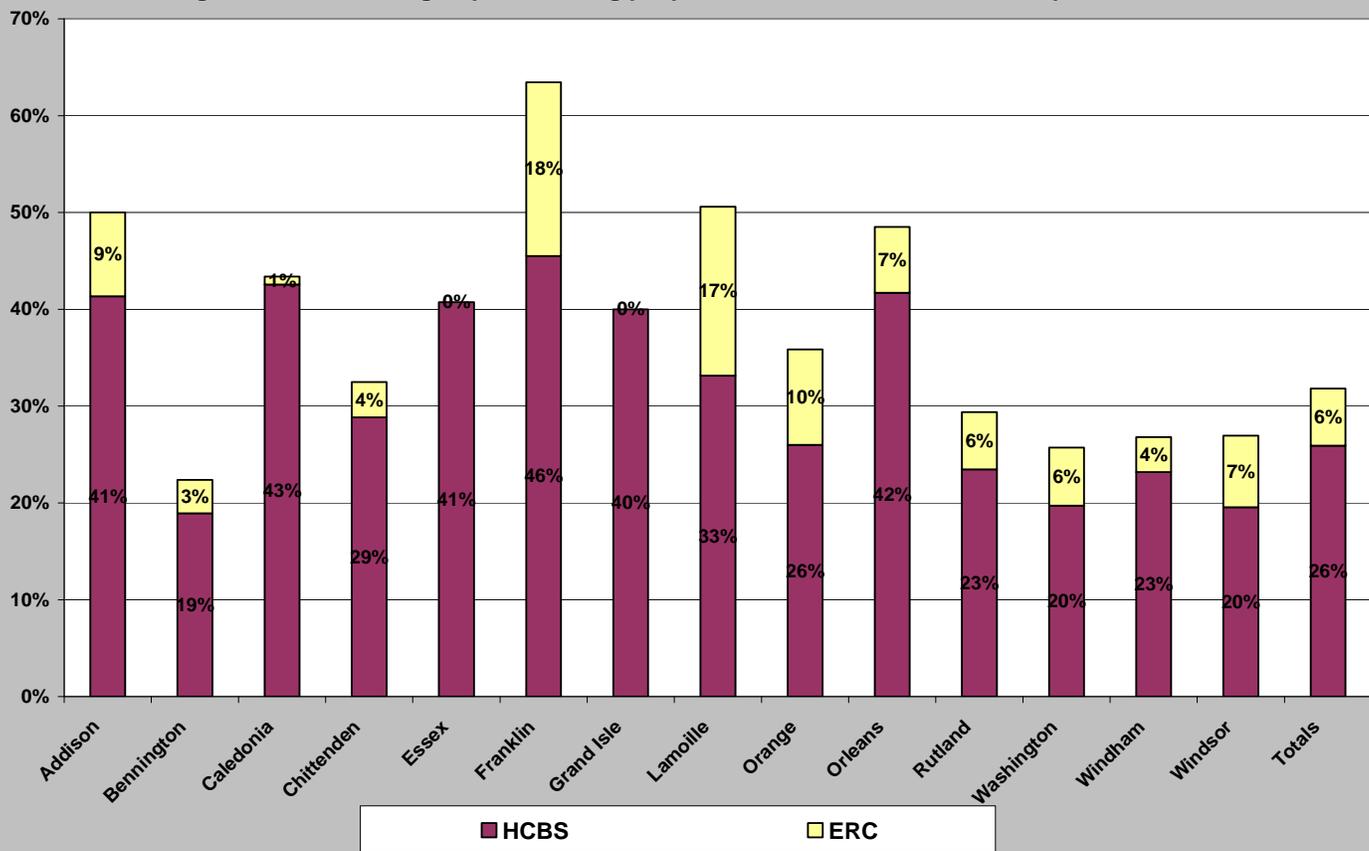
This provides a demographic perspective on Choices for Care enrollment in each county, based on estimates of total demographic need. The data does not include the Moderate Needs Group.

The chart is based on *Shaping the Future of Long Term Care and Independent Living* by Julie Wasserman (May 2007), which includes two estimates of need: nursing homes and community 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 currently served, producing an estimate of the percentage of people in need who are actually served.

While it would not be reasonable or feasible to attempt to serve 100% of the estimated number of people who may need assistance, this graph does provide a perspective on the relative numbers of people served in each county.

**Choices for Care: Number of People Served by Setting as a Percentage of Estimated Community Need by County - July, 2007**

Aged 18+, all income groups, excluding people with mental retardation/developmental disabilities



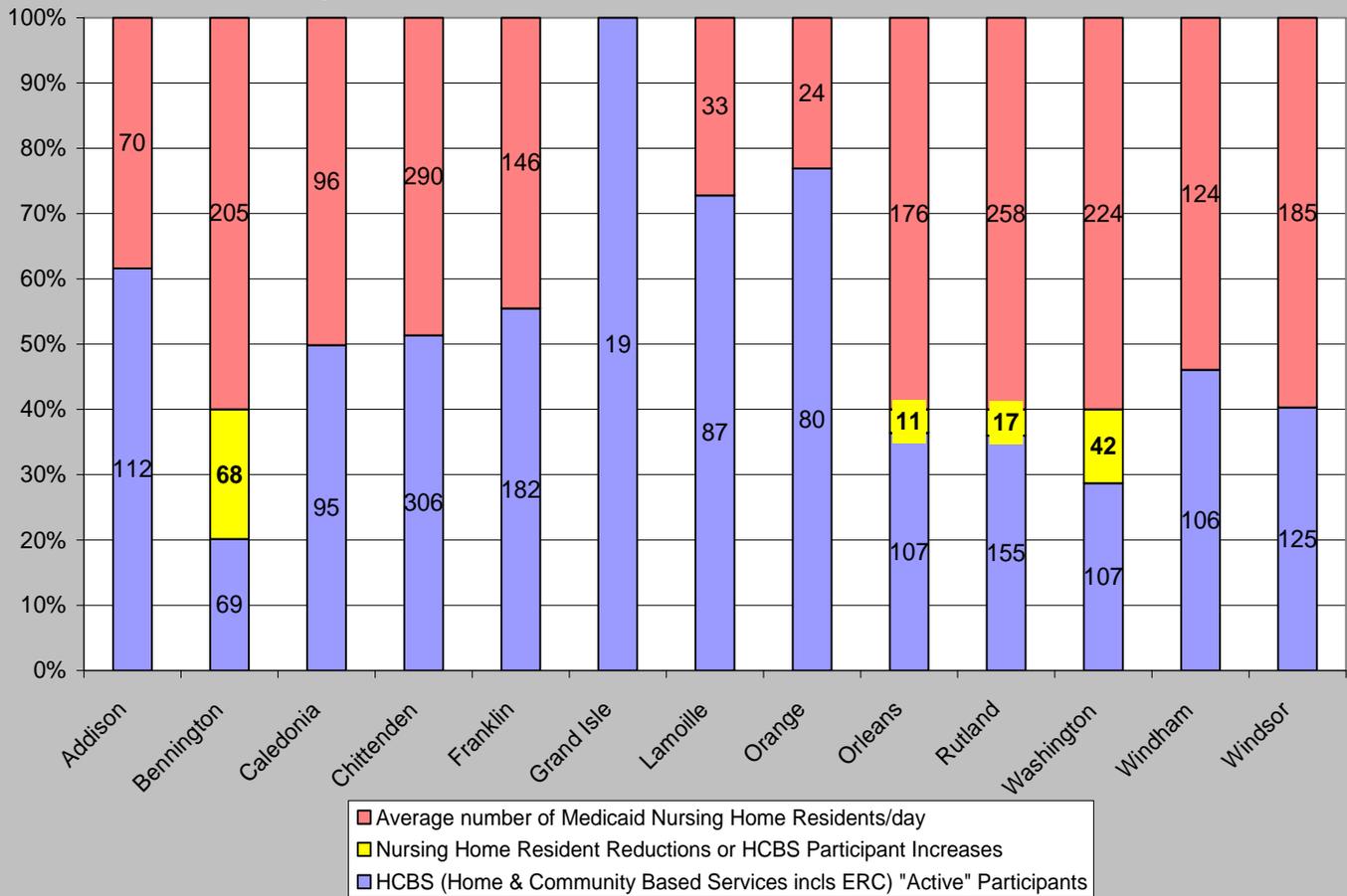
Data sources: DAIL/DDAS SAMS database; *Shaping the Future of Long Term Care and Independent Living* 2007.

This provides a slightly different demographic perspective on Choices for Care enrollment in each county, with a focus on alternative settings. The data does not include the Moderate Needs Group.

The graph is based on estimates of need for assistance in community settings only (*not* nursing home settings), as presented in *Shaping the Future of Long Term Care and Independent Living*, by Julie Wasserman (May 2007). The estimates of need include all people aged 18 and over with two or more ADL assistance needs, all income groups. The total community need was then compared to the number currently served in the community, producing an estimate of the percentage of people in need in the community who are actually served.

Again, it is neither reasonable nor feasible to attempt to serve 100% of the estimated number of people who need assistance. This graph does provide a perspective on the relative numbers of people served in community settings in each county.

## Medicaid Choices for Care: Nursing Home Residents and Home & Community-Based Participants--April 2007 Changes (Yellow) Needed to Achieve 60/40 Balance



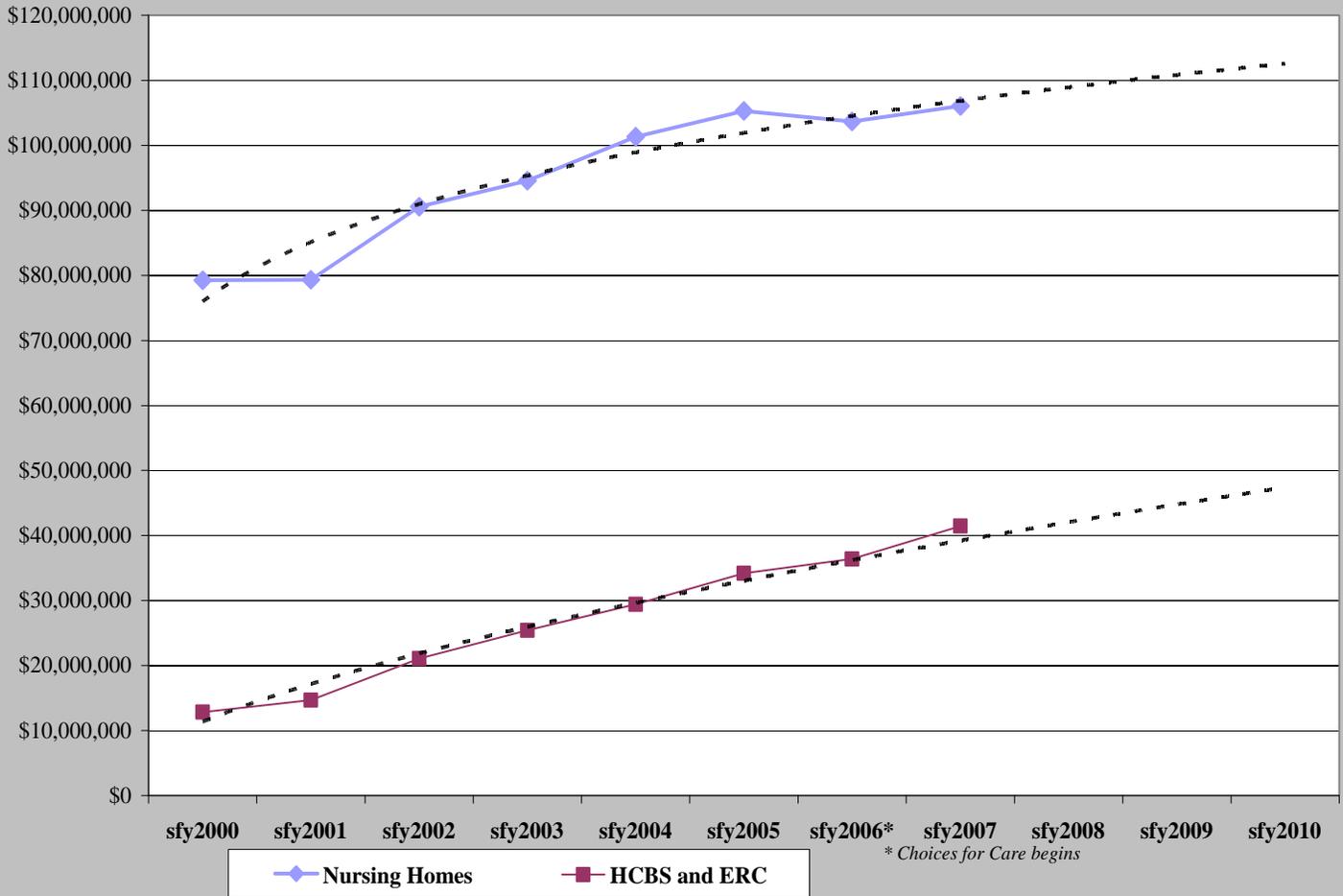
Data sources: DAIL/DDAS SAMS database; Division of Rate Setting.

One of the goals of Choices for Care is to serve a higher percentage of people using Medicaid-funded long term care in alternative community settings, and to reduce reliance on nursing homes. This graph illustrates our status in achieving this goal in each county as of April 2007.

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 40% in alternative settings (yellow).

In Addison, Chittenden, Franklin, Grand Isle, Lamoille, and Orange Counties, more than 50% of Choices for Care participants are now served in alternative settings. In Caledonia, Windham and Windsor Counties, more than 40% of participants are served in alternative settings. People using Medicaid long term care in the remaining counties - Bennington, Orleans, Rutland, and Washington- remain more dependent on nursing homes, with less than 40% served in alternative settings.

### Vermont LTC Expenditures by Type, sfy2000-sfy2007

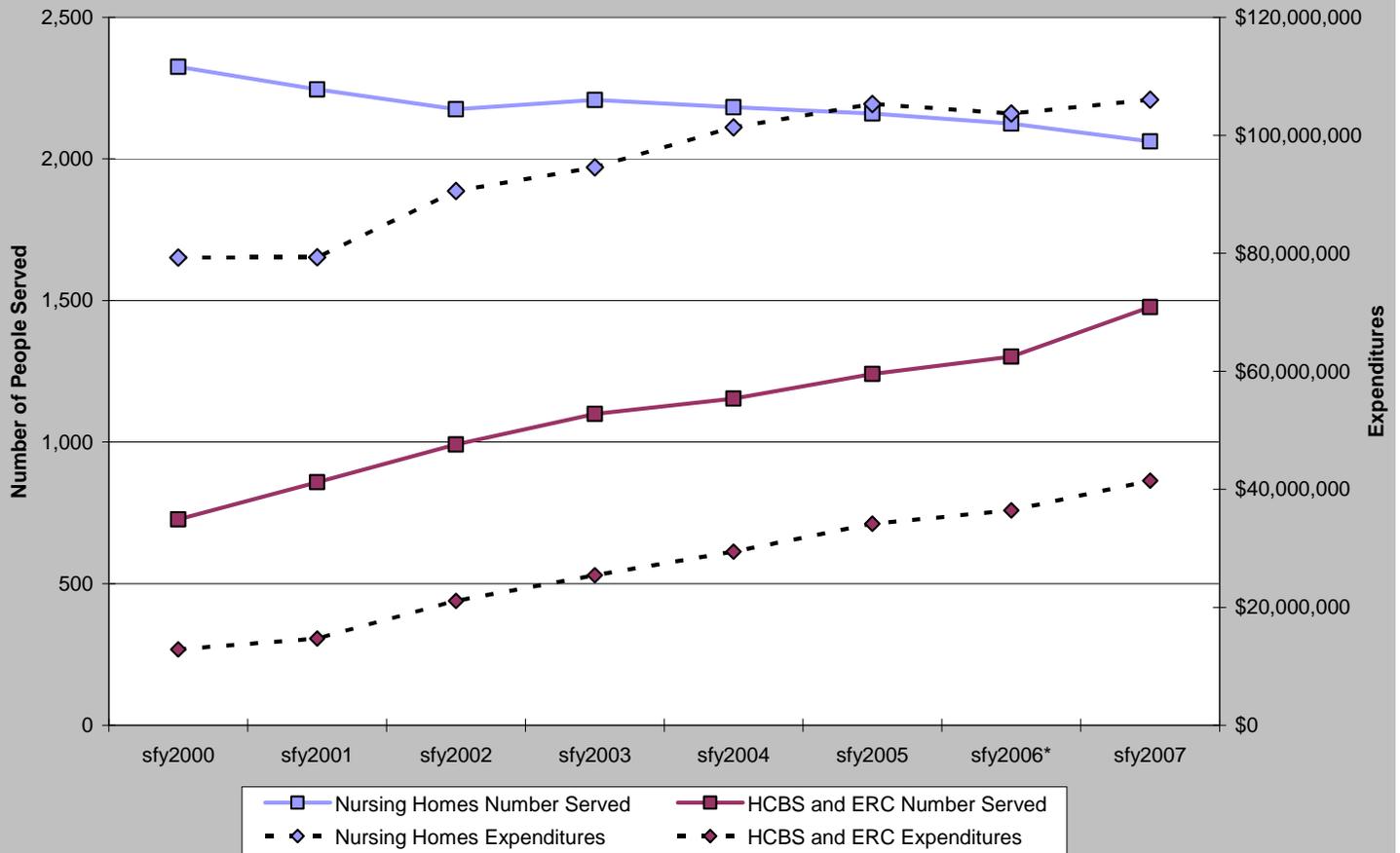


Data source: DAIL Monthly Monitoring Report

This graph shows direct Medicaid long term care expenditures by setting. Since sfy2000, annual 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 support services (housing subsidies, transportation, food, utilities, etc.) People in nursing homes and enhanced residential care tend to incur fewer of these other expenditures.

Vermont LTC: Expenditures and People Served by Setting, sfy2000-sfy2007

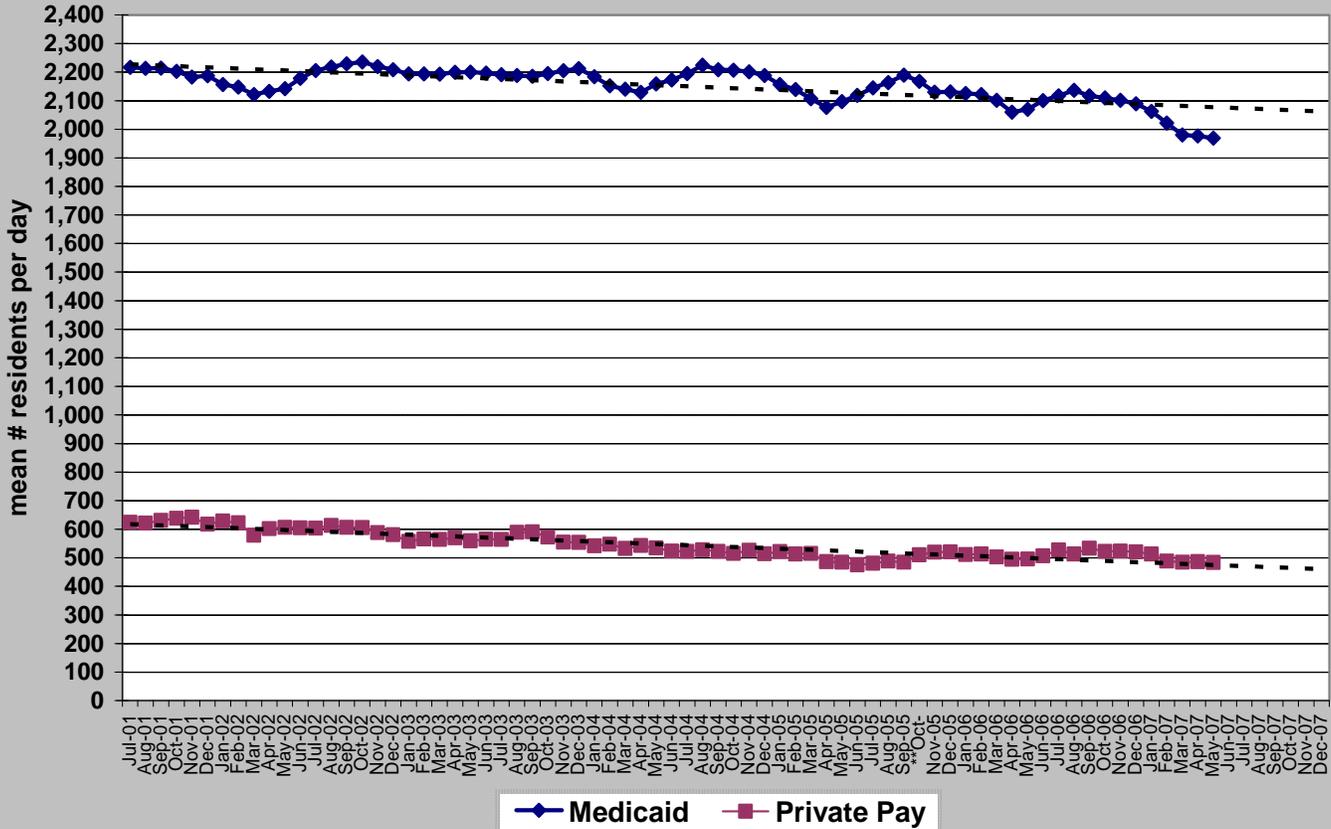


Data sources: DAIL/DDAS SAMS database; DAIL Monthly Monitoring Report

This shows trends in both the average numbers of people served and total expenditures by setting. As noted, expenditures have increased by similar amounts in both settings. These increases are related to different patterns in the number of people served: the number of people served in nursing homes has decreased, while the number served in alternative settings has increased substantially.

## Vermont Nursing Home Bed Use: Medicaid and Private Pay Average Number of Residents per Day, July 2001- May 2007

(data source: DRS monthly census reports; out of state nursing homes, hospital swing beds not included)



\*\*Oct-05\*\*: beginning of Choices for Care

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

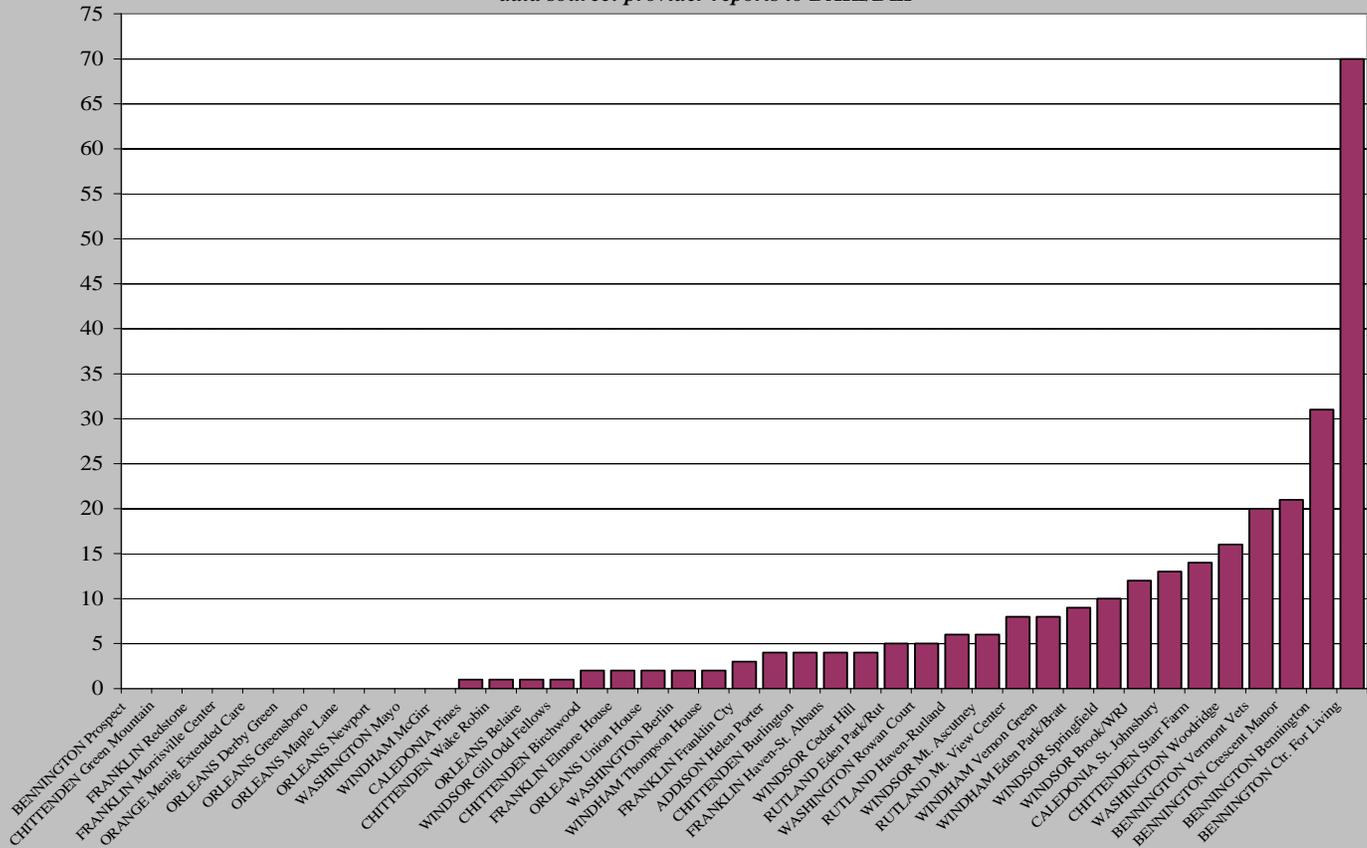
This shows trends in nursing home use over time for people whose primary payor was Medicaid, as well as for people who paid privately. These average occupancy figures are computed from monthly census figures reported by Vermont nursing homes to the Division of Rate Setting.

Consistent with other data sources, this data suggests that the number of Medicaid nursing home residents has decreased over time- about 200 people between October 2005 and May 2007. Note that nursing home closings and other reductions in the number of licensed beds have contributed to this decrease.

The number of private pay residents has decreased slightly since October 2005. Long term care Medicaid financial eligibility requirements have become more rigorous, which would tend to increase the number of nursing home residents who pay privately. However, more people may be paying privately for community-based services, which would tend to reduce the number of nursing home residents who pay privately.

**Vermont Nursing Homes: Out of State Admissions by Facility and County,  
January 2007- May 2007**

*data source: provider reports to DAIL/DLP*

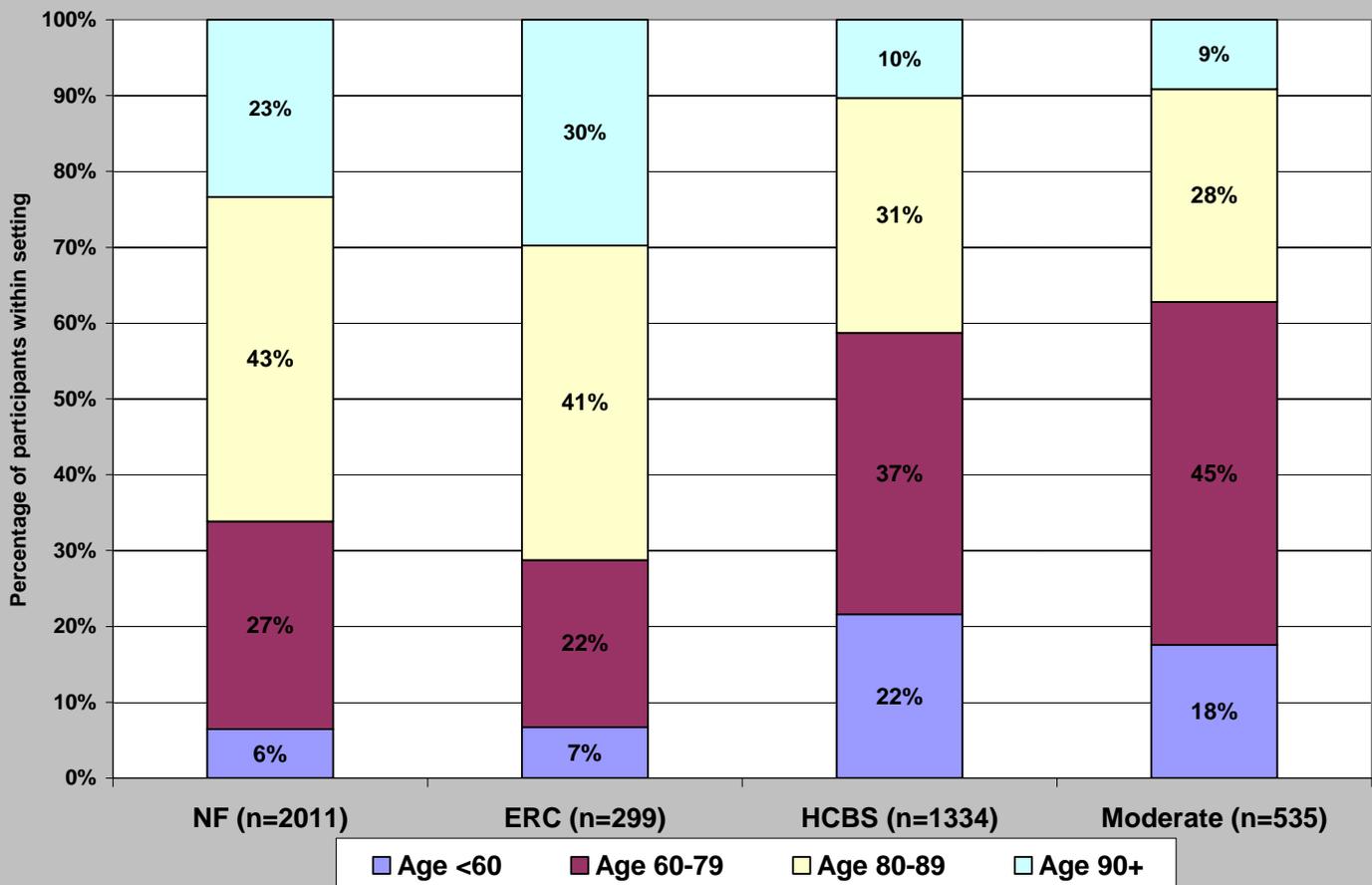


*Data source: DAIL Division of Licensing and Protection*

Concerns are occasionally expressed about residents of other states who are admitted to Vermont nursing homes and subsequently become eligible for Vermont long term care Medicaid. This graph shows admissions of residents of other states to nursing homes in Vermont, as reported to the DAIL Division of Licensing and Protection. Note that citizens have the legal right to move freely within the United States, including the right to change state residency and to apply for Medicaid in the state in which they reside.

While thirty nursing homes admitted at least one person from another state, only nine nursing homes admitted more than ten people from other states. Just four nursing homes admitted twenty or more: Center for Living (70), Bennington Health and Rehabilitation Center (31), Crescent Manor (21), and Vermont Veteran’s Home (20). These four Bennington County nursing homes represented nearly half of all admissions from other states. The number of these people who are (or will be) served under Choices for Care is currently unknown. Changes to the Choices for Care application form would allow more accurate tracking of the original residency of people who use Choices for Care services - both from other states and within Vermont.

## Choices for Care: Active Participants by Setting by Age, July 2007



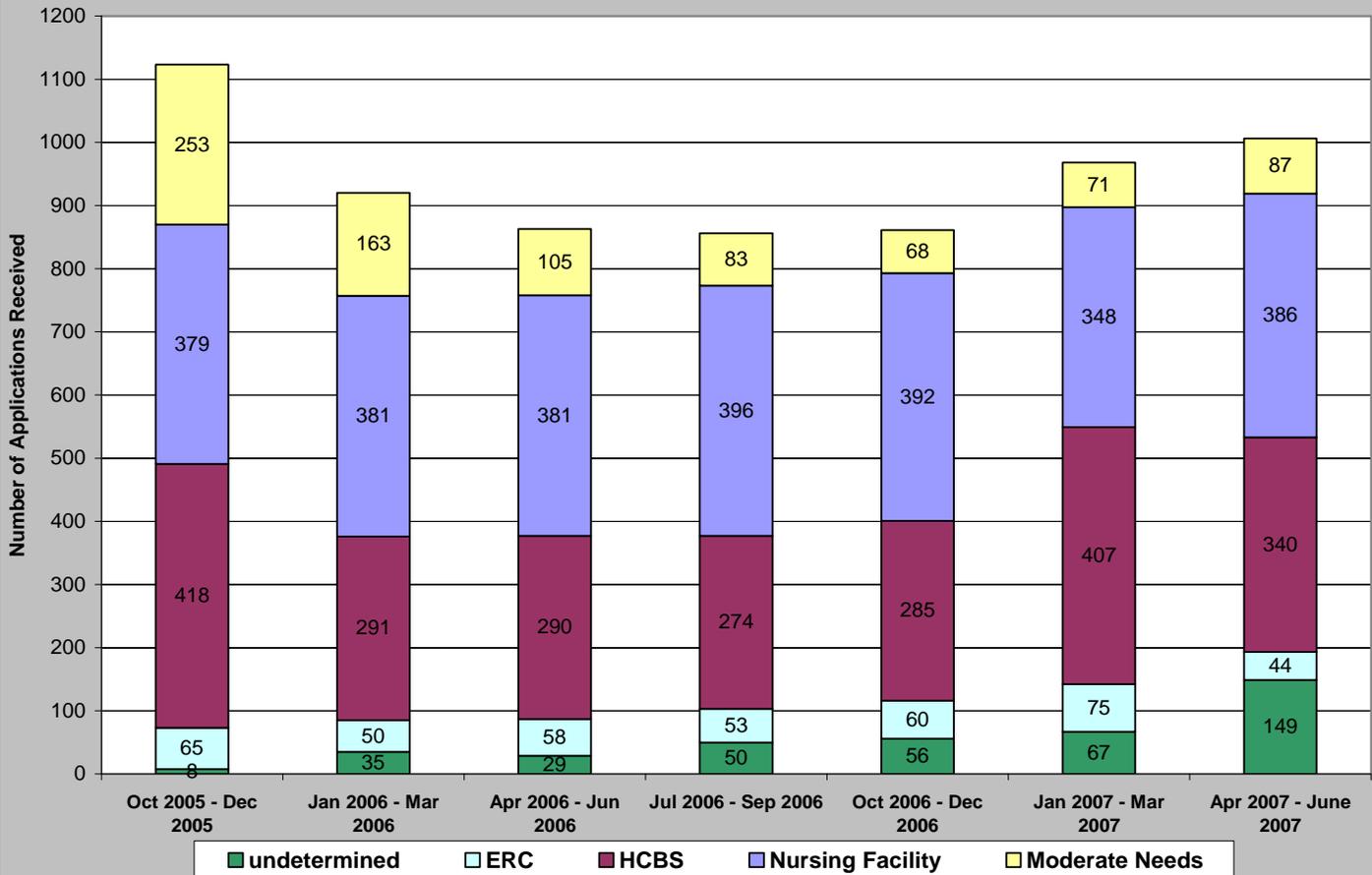
Data source: DAIL/DDAS SAMS database.

This graph shows the ages of participants within four groups of Choices for Care participants: Nursing Facility, Enhanced Residential Care, Home and Community Based Services, and the Moderate Needs Group.

The median age of people enrolled in the HCBS Highest/High Needs Groups is nearly 80. However, many younger people are also served in Choices for Care, including over 400 people under the age of 60.

Overall, more than half of the Choices for Care participants are aged 80 or older, and nearly 20% are aged 90 or over. The highest percentage of people aged 80 and over is found in the Enhanced Residential Care setting, followed by the Nursing Facility setting. The highest percentage of people under the age of 60 is found in the HCBS setting.

**Choices for Care: Applications Received by Service Program  
October 2005 through June 2007**



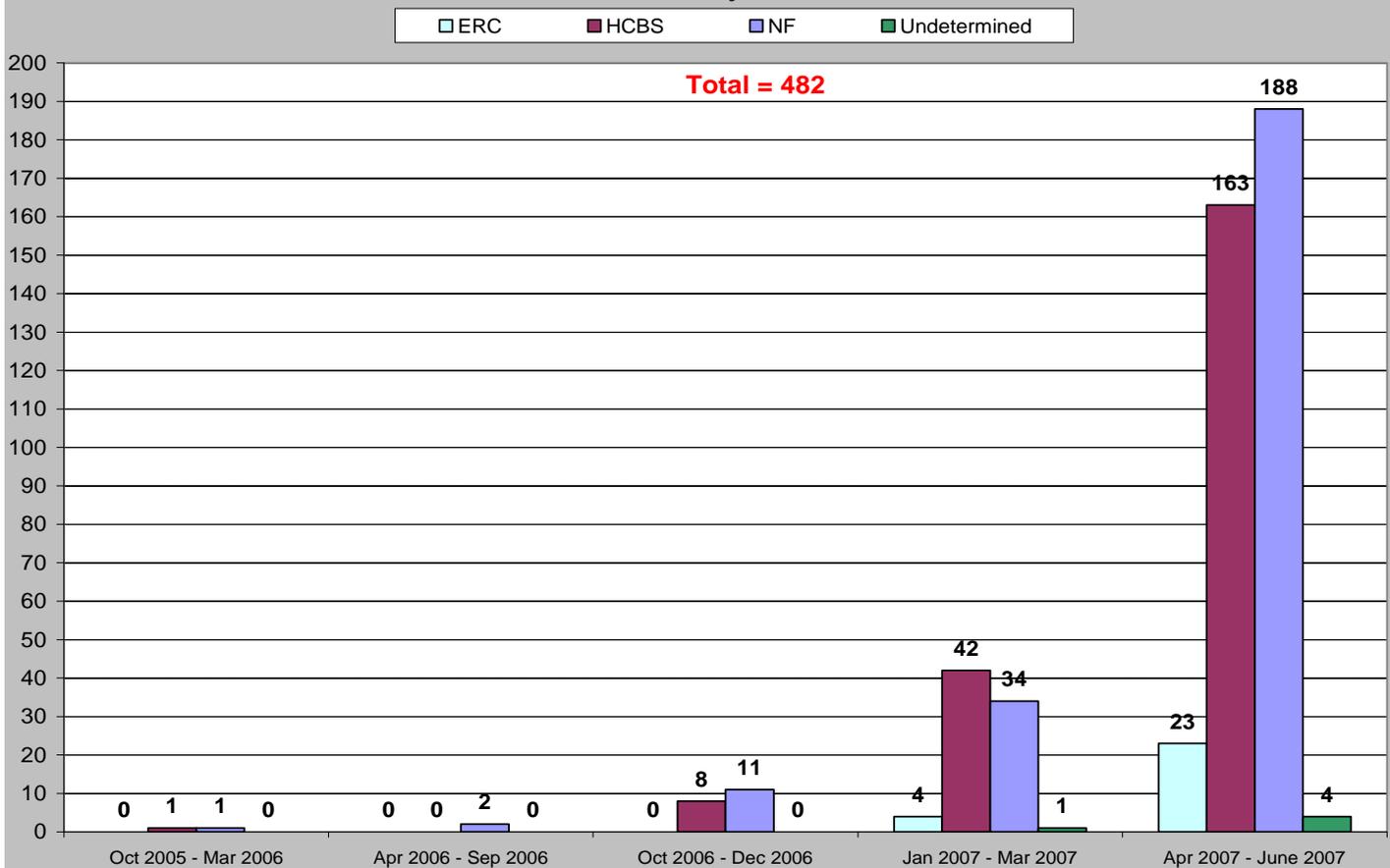
Data source: DAIL/DDAS SAMS database.

This graph shows the numbers of Choices for Care applications received over time. This data is useful in viewing changes in overall ‘demand’ over time, and in changes in demand among the different settings. It also provides a measure of staff workload in processing applications at DAIL and at the Department of Children and Families.

The preexisting waiting lists for HCBS and ERC services (241 people in September 2005) contributed to a large number of applications in October and November 2005. In subsequent months, the number of applications stabilized, but the number of applications has increased again in the last six months. DAIL/DDAS currently receives more than 300 applications each month.

About 40% of applications are for Nursing Facilities (including short-term and rehabilitation nursing home admissions.) About 40% are for Home and Community Based Services, about 8% for Moderate Needs Group, and about 8% for Enhanced Residential Care. The percentages of applications for Home and Community Based Services and for Enhanced Residential Care have increased slightly over time.

**Choices for Care: Applications 'Pending Medicaid' by Status Date  
October 2005 through June 2007  
as of July 2007**



Data source: DAIL/DDAS SAMS database.

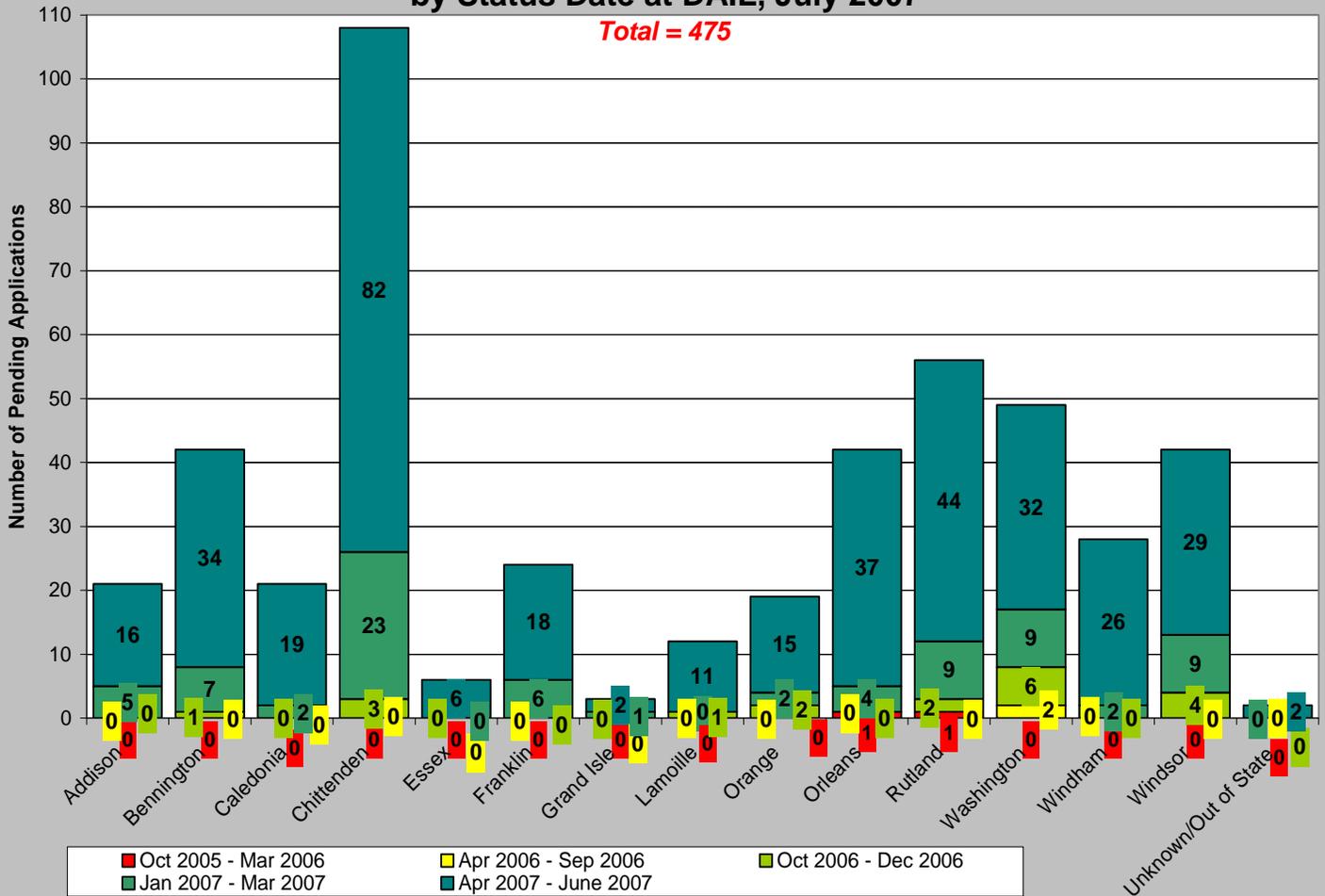
One of the goals of Choices for Care is to help Vermonters access long term care when they need it. An indicator of our success in achieving this goal is the time required to process individual applications.

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

1. Long-term care Medicaid applications are never submitted.
2. Long-term care Medicaid applications are delayed or incomplete.
3. 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.
4. Some applications lead to complicated asset searches and/or legal review by the Department for Children and Families (DCF).

Staff from DAIL and DCF continue to work to find ways to process Choices for Care applications as accurately and as quickly as possible. Ongoing communication and collaboration between DAIL regional staff, DCF regional staff, and local case managers contributes to the timely processing of applications.

## Choices for Care: Pending Medicaid Applications by County by Status Date at DAIL, July 2007



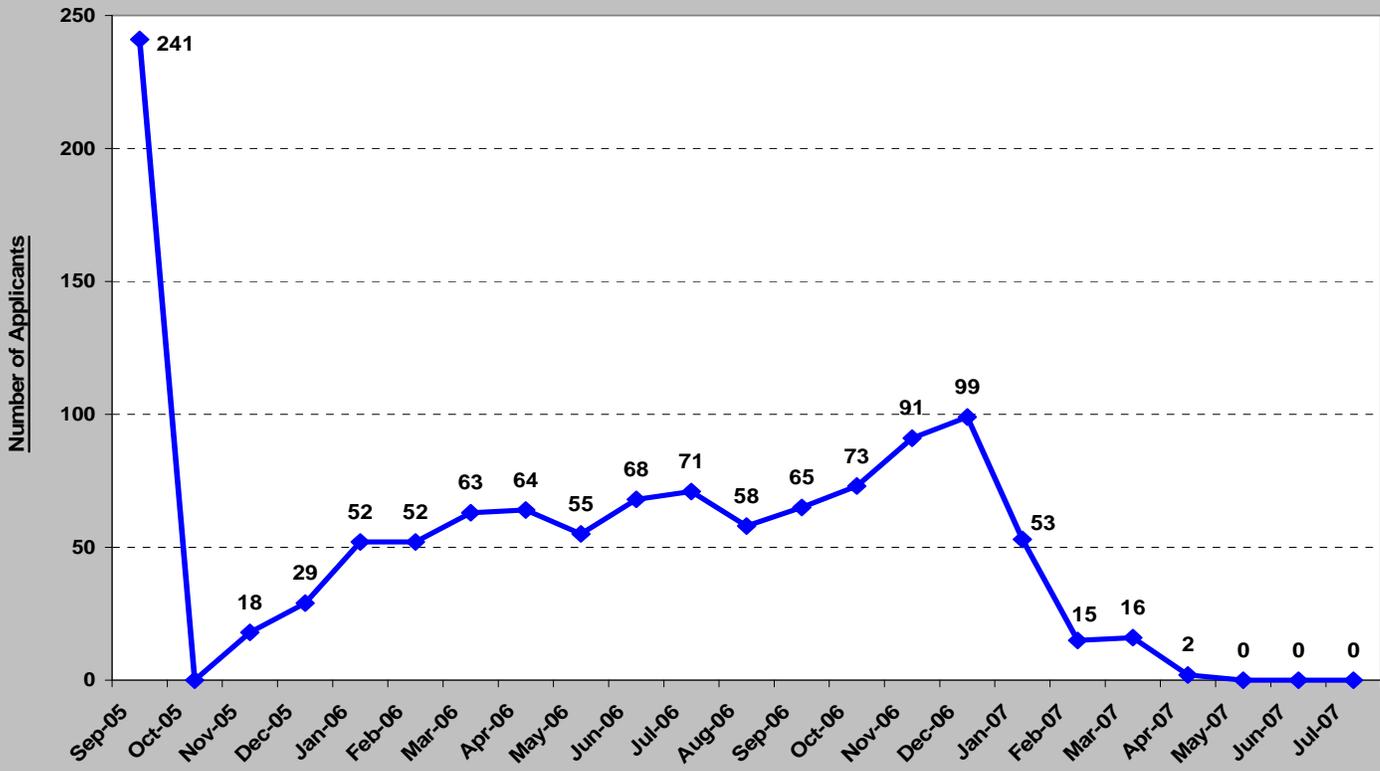
Data source: DAIL/DDAS SAMS database.

The number of ‘old’ pending applications can be used as an indicator of success in ensuring timely access to services across Vermont. This also provides a measure of DAIL and DCF staff workload within each county.

Orange, Washington and Windsor counties appear to have high percentages of ‘old’ applications. DAIL staff are working with DCF staff to ensure that this data is accurate, and to process applications.

The total number of pending applications is related to the size of the county’s population, but this relationship is not entirely consistent across the state. Relative to estimates of long term care need, Bennington, Essex, Orleans, Orange and Chittenden counties have more pending applications than other counties.

**Choices for Care High Needs Waiting List, by Month  
September 2005 - July 2007**



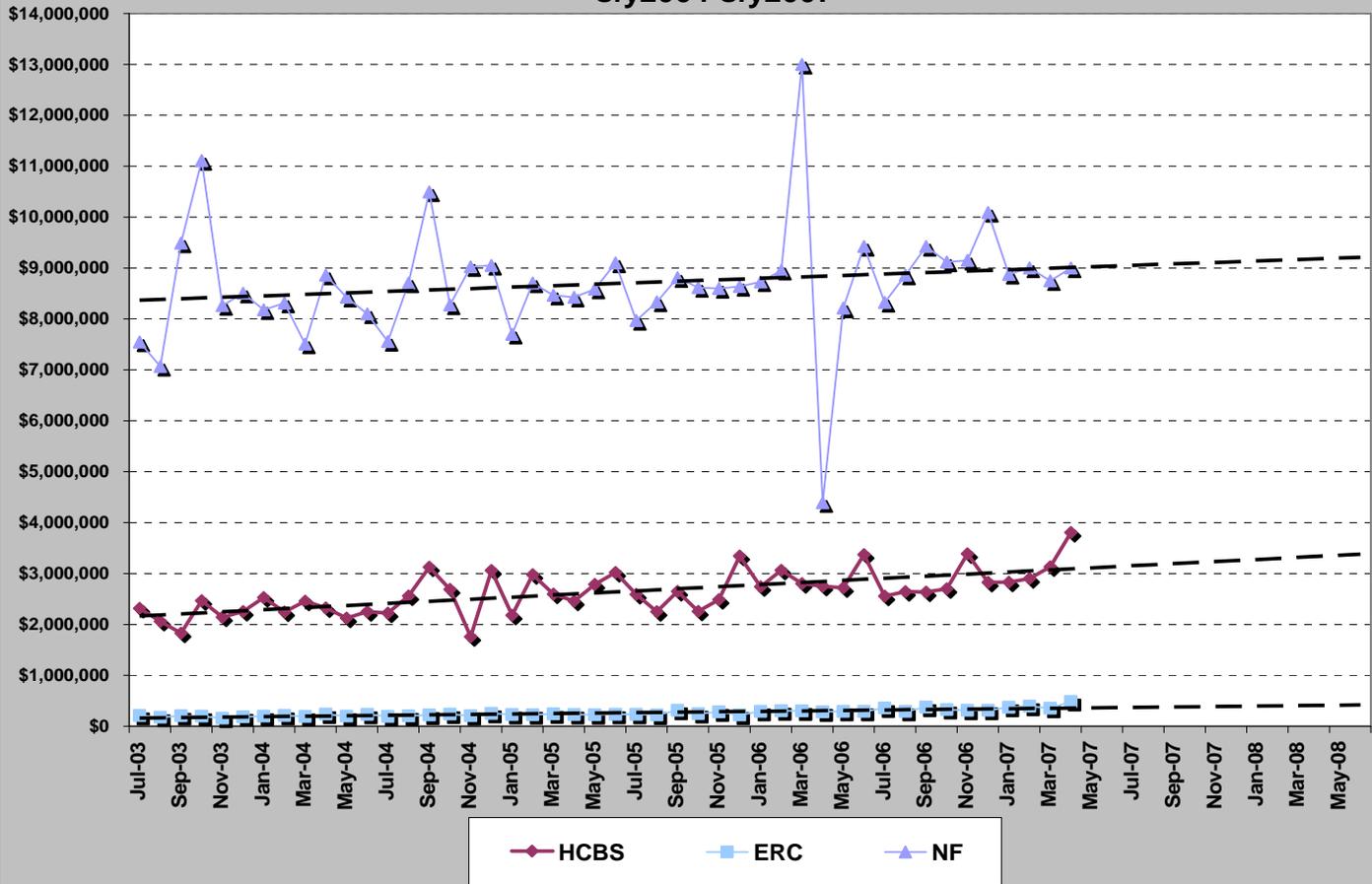
Data source: DAIL/DDAS SAMS database.

A goal of Choices for Care is to improve access to home and community based services. One measure of access is the number of people on waiting lists. Note that 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 many states, the 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, access to Home and Community Based Services and Enhanced Residential Care were limited by available funds, and Vermonters were often placed on waiting lists. The total number of people on waiting lists fell when Choices for Care was implemented in October 2005, when all applicants who met the Highest Needs Group eligibility criteria became entitled to services.

Beginning in October 2005, 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. Since January 2007, all High Needs Group applicants have been enrolled, and the waiting list has disappeared.

### Vermont Long Term Care: Monthly Expenditures by Category sfy2004-sfy2007



Data source: DAIL Monthly Monitoring Report.

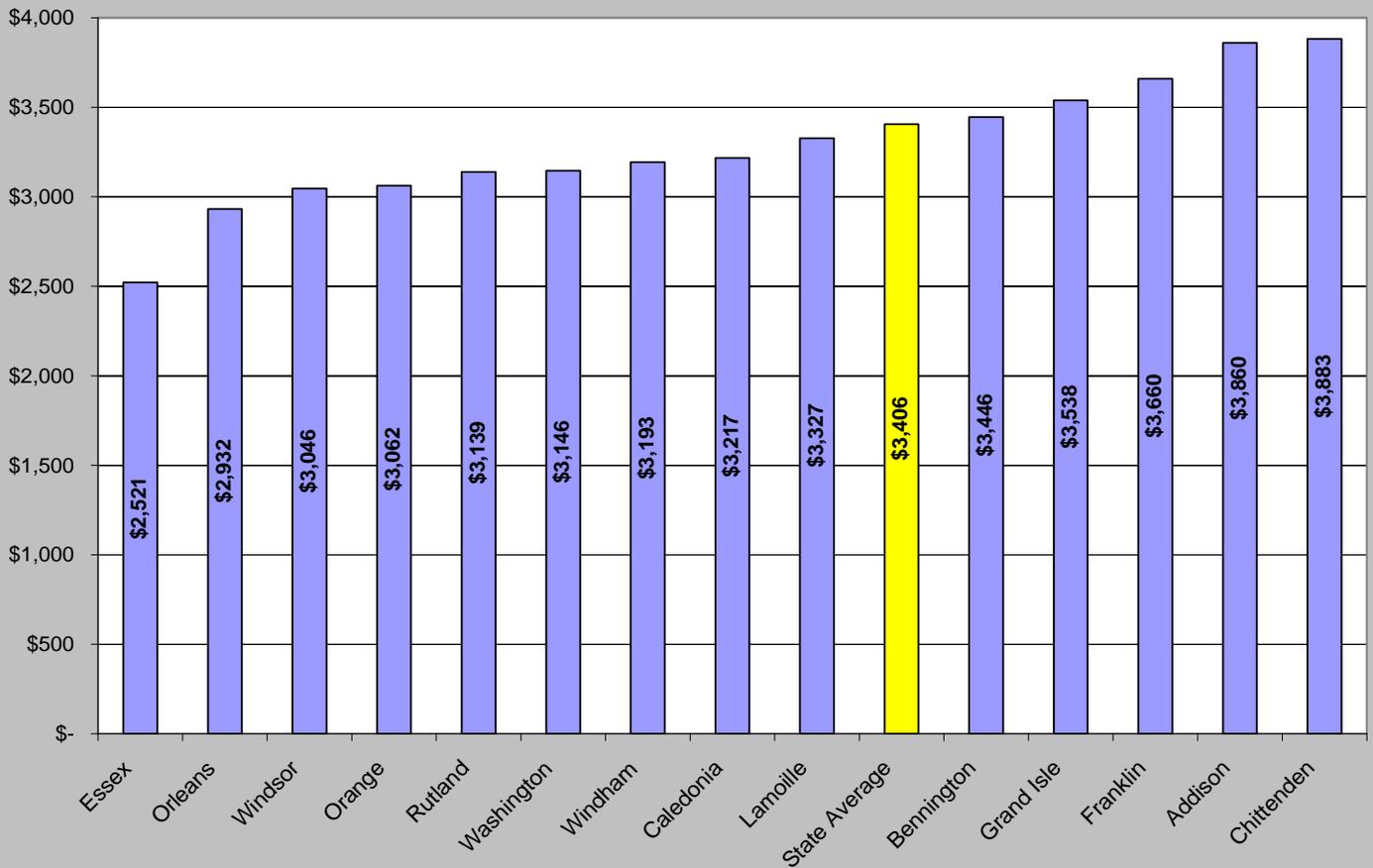
This shows monthly Medicaid long term care payments by setting. These payment figures are adjusted to include third party payments and other cash adjustments, including estate recovery.

Nursing Facilities (NF) currently represent about 70% of current Choices for Care expenditures. Home and Community Based Services (HCBS) and Enhanced Residential Care expenditures represent about 30%. In comparison, about 55% of highest and high needs participants are served in Nursing Facilities, while about 45% of these participants are served in alternative settings.

Average monthly expenditures for Enhanced Residential Care have grown the most in recent years, increasing about 80% since the beginning of sfy2004. In the same time period, Home and Community Based Services expenditures have increased about 40%, and Nursing Facility expenditures have grown about 4%.

## Choices for Care: Average Monthly Cost of Approved HCBS Plans of Care by County, July 2007

(Highest and High Needs Groups only)



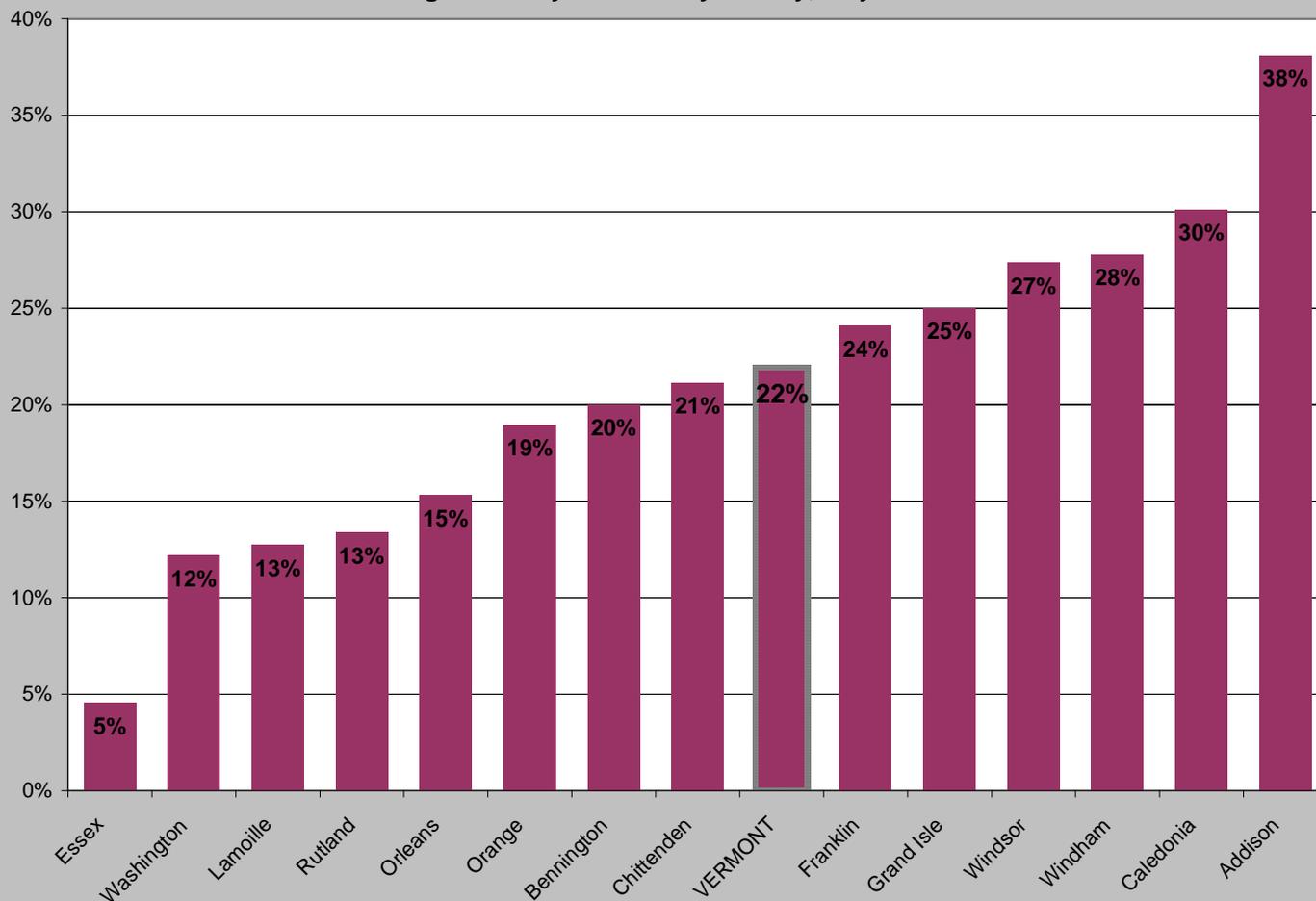
Data source: DAIL/DDAS SAMS database.

The average approved cost of HCBS Highest/High Needs Group Plans of Care was \$3,406. The average costs in Chittenden, Addison, and Franklin Counties were well above the state average. The average cost in Essex and Orleans Counties was well below the state average.

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

1. Higher use of Home Health Agency personal care services, at a higher reimbursement rate.
2. Higher number of hours of personal care services.
3. Higher use of adult day services.
4. Lower use of home health services (nursing and licensed nurse assistants) supported by Medicare or Medicaid.

**Choices for Care: Percentage of Active Highest/High Needs Participants Using Adult Day Services by County, July 2007**

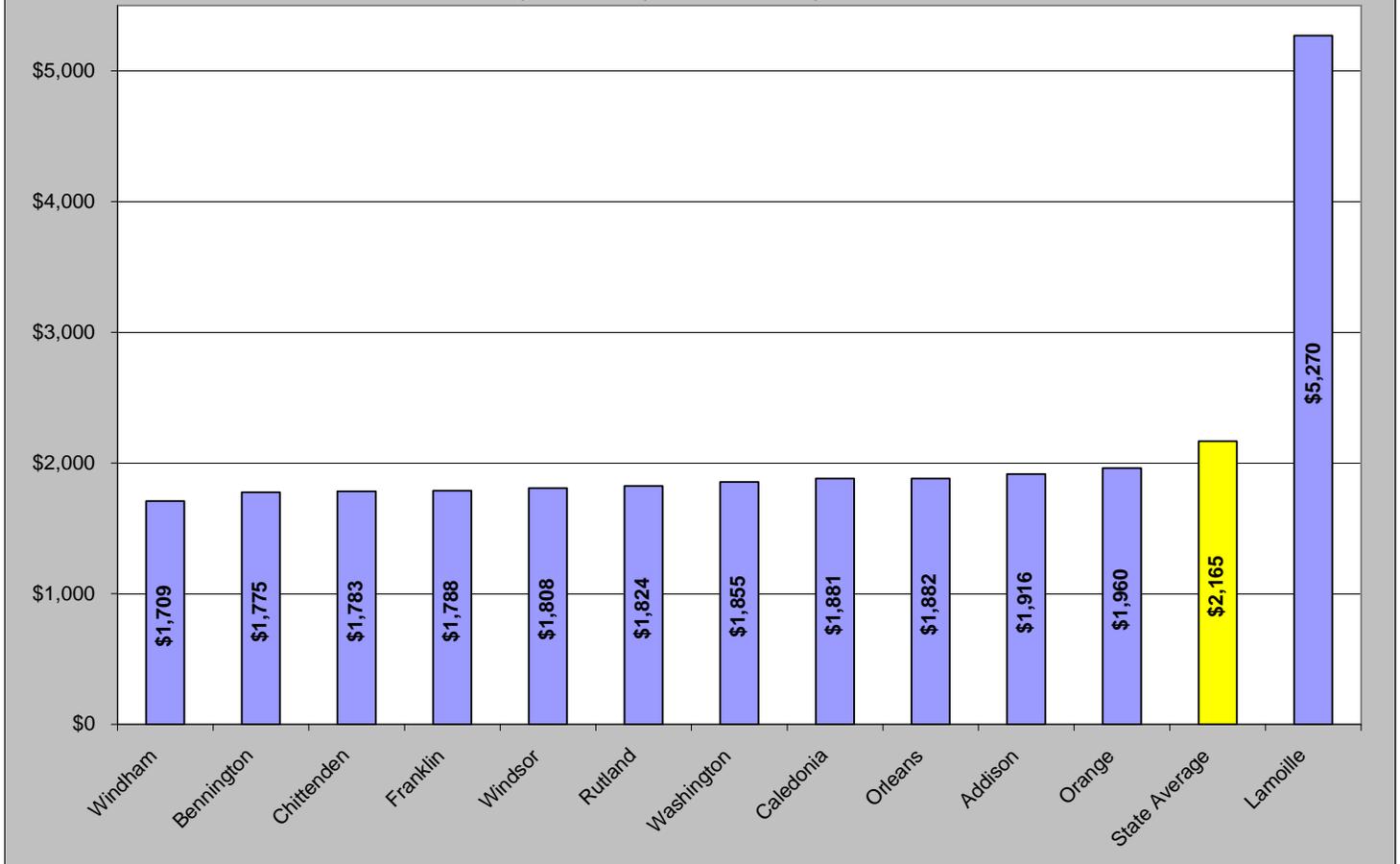


Data source: DAIL/DDAS SAMS database.

This shows the percentage of active High Needs Group and Highest Needs Group participants who were approved to use adult day services in each county.

Statewide, just over 20% used adult day services. More than 25% used adult day services in Addison, Caledonia, Windham, and Windsor Counties. Less than 15% used adult day services in Essex, Washington, Lamoille, and Rutland Counties.

### Choices for Care: Average Cost of Approved ERC Plans of Care by County, as of July 2007



Data source: DAIL/DDAS SAMS database.

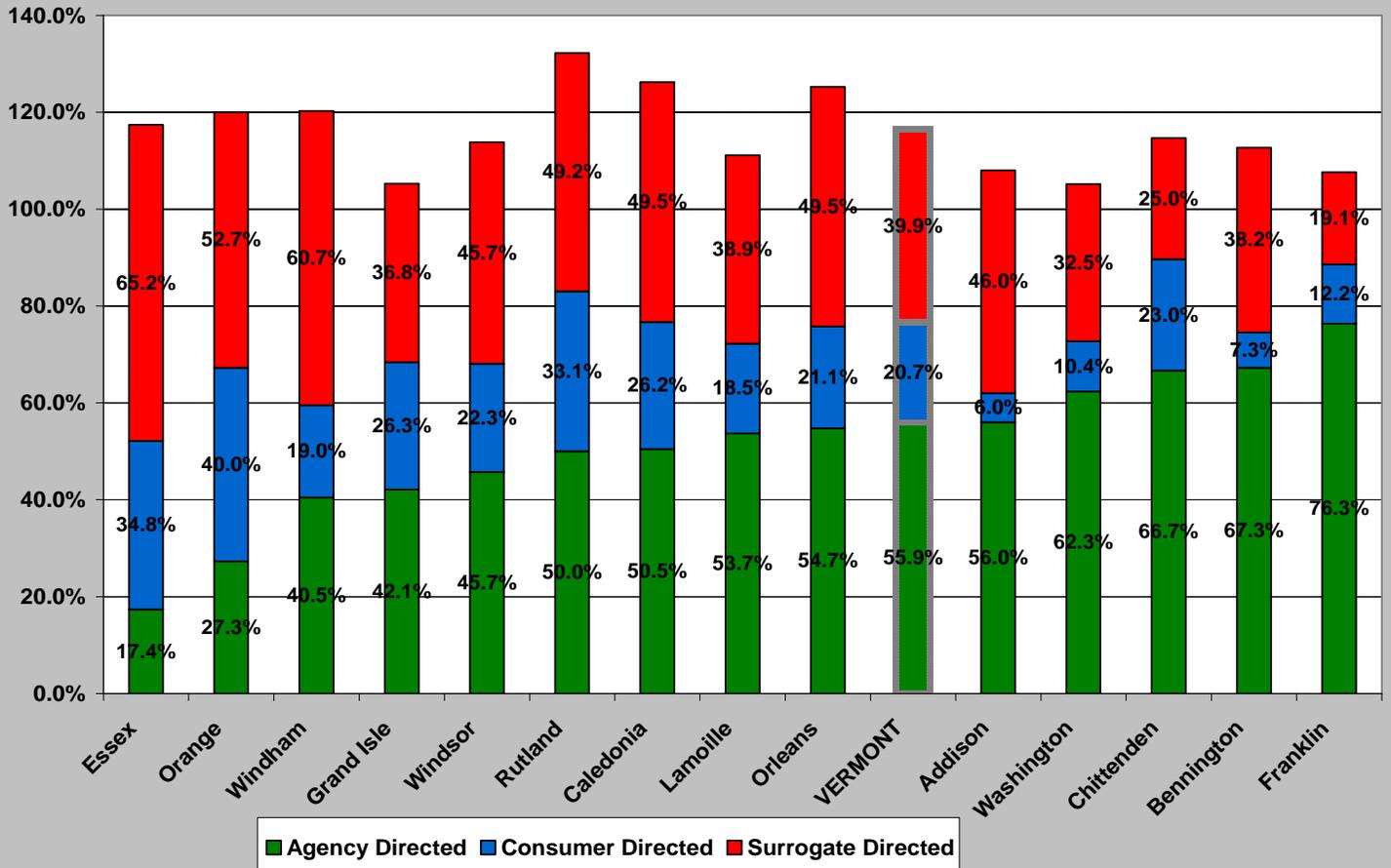
The average approved cost of ERC Highest/High Needs Group plans of care was \$2,165. This is nearly 40% less than the average approved cost of HCBS plans of care.

The highest costs were found in Lamoille County. This results from special rates paid to Lamoille County providers to serve a small number of people who were discharged from Morrisville Center nursing home and from Traumatic Brain Injury services.

There is no consistent relationship between approved HCBS costs and approved ERC costs by county. Addison county had high ERC plan of care costs as well as high HCBS plan of care costs. Chittenden and Franklin counties had low ERC plan of care costs but high HCBS plan of care costs.

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 are based on three daily reimbursement 'tiers' which directly reflect the functional and cognitive status of ERC participants but do not represent a specific number of hours of personal care. ERC plans of care do not include adult day services, which contributes to higher HCBS plan of care costs.

### Choices for Care: Personal Care Services by County by Type July 2007



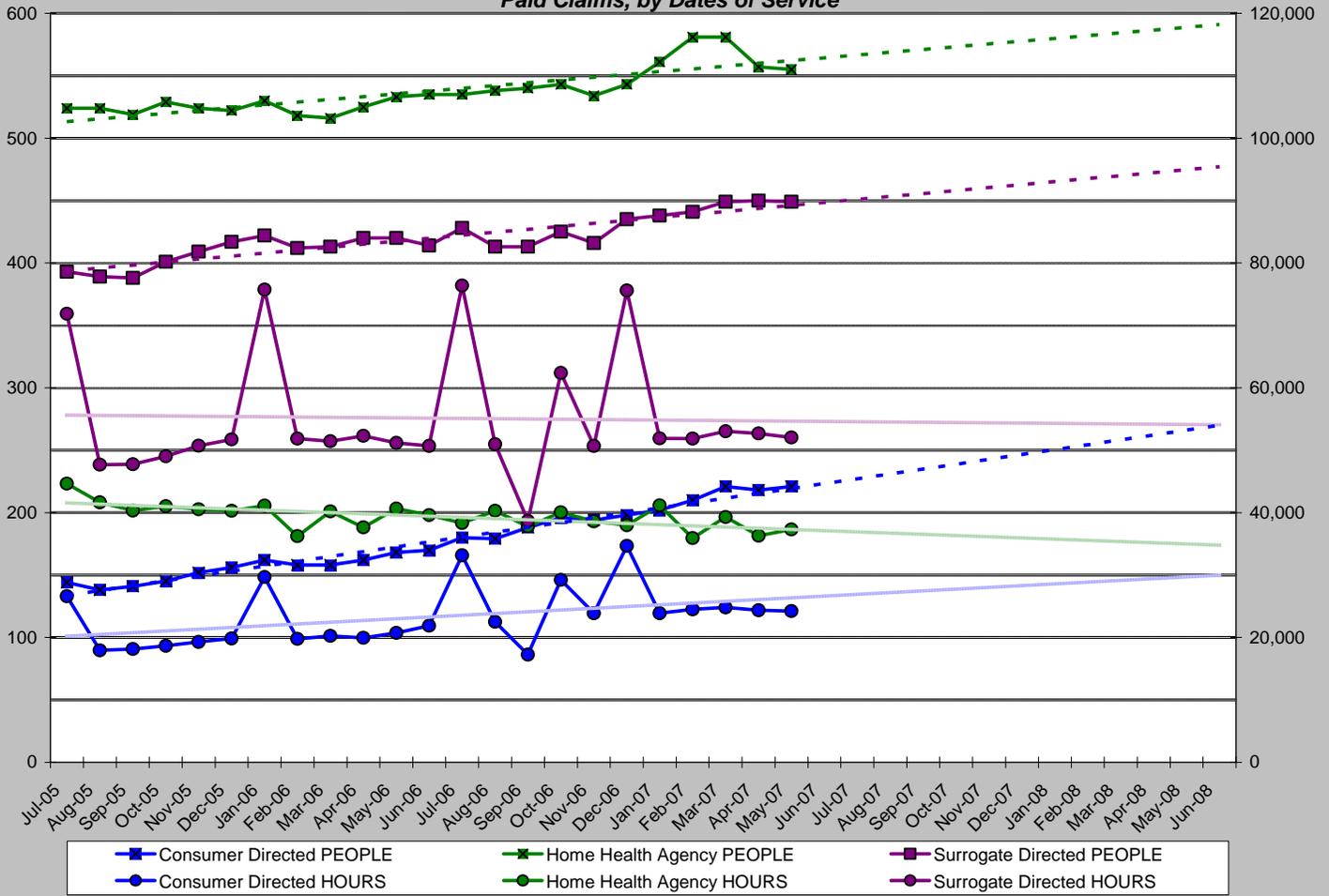
Data source: DAIL/DDAS SAMS database. Includes people who receive more than one type of personal care service.

This shows the percentage of people who were approved to use each type of personal care services in each county, using DAIL/DDAS SAMS data. Note that this reflects the services that people were approved to use, not what they actually did use.

Statewide, about 56% of people had service plans that included some home health services, and about 61% had plans that included consumer or surrogate directed services. About 17% of the people plan to combine home health agency services with consumer or surrogate-directed services. Because of this, the totals are higher than 100%.

In every county, significant numbers of people had plans with each type of service. However, there are significant variations among the counties. In Franklin, Bennington, Chittenden, and Washington counties, a high percentage of people had service plans with home health services. In Essex, Orange, Windham, and Grand Isle counties, a low percentage of percentage of people had service plans with home health services. In counties with lower use of home health services, people seem to have used both consumer and surrogate directed services as an alternative.

**Choices for Care: Use of Personal Care Services by Type, sfy2006-sfy2008**  
**Total Numbers of People and Hours of Service**  
*Paid Claims, by Dates of Service*



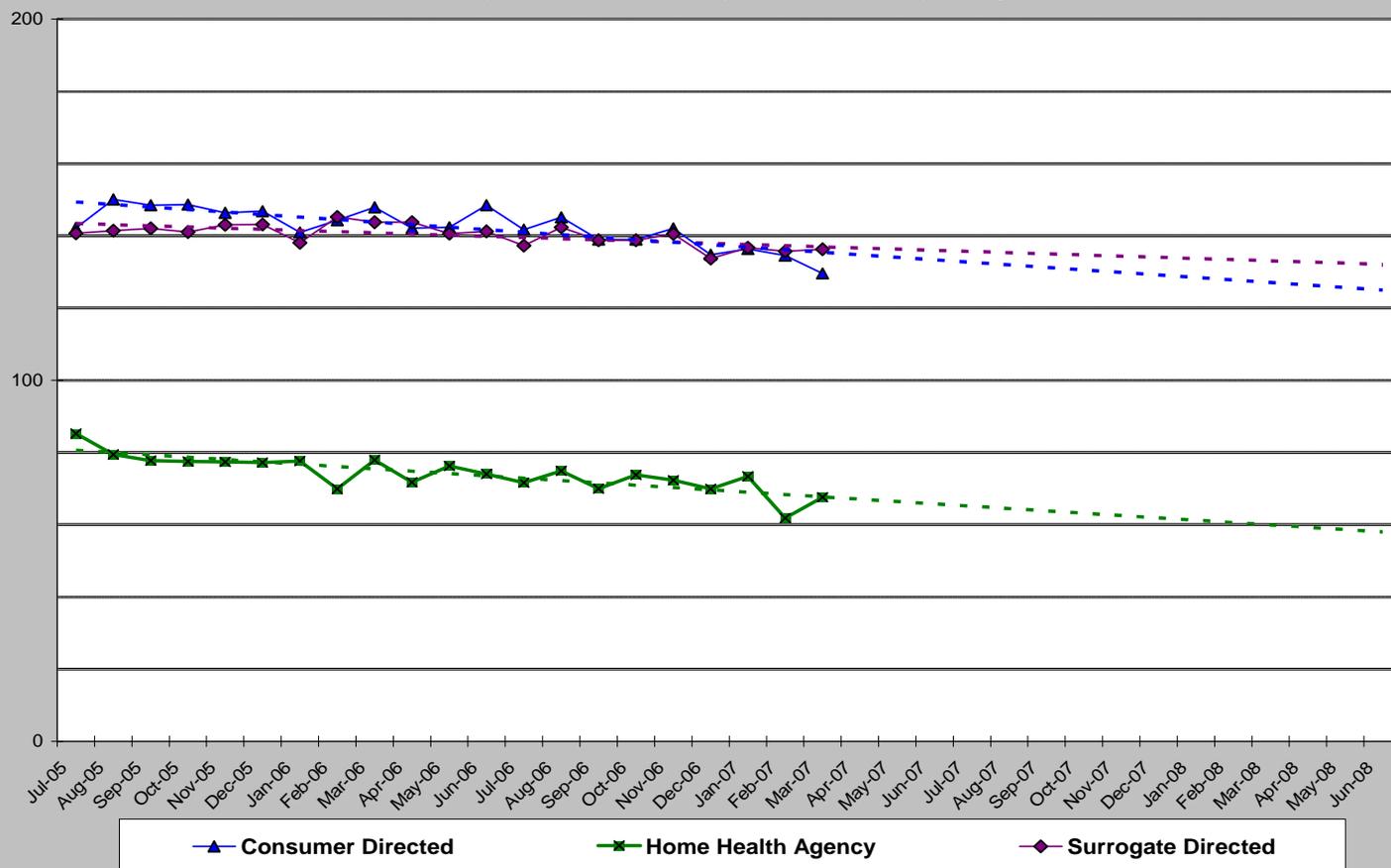
Data source: EDS paid claims, by date of service

This graph shows recent trends in paid Medicaid claims (by dates of service) for the three different 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. The largest increase has been in the number of people using consumer-directed services. The numbers of people using home health services and surrogate-directed services have increased at a similar rate. The data for recent months suggests the following:

<i>option</i>	<i>% of people</i>	<i>% of hours</i>	<i>service volume</i>
Home health	50%	35%	slight decrease
Consumer directed	15%	20%	increase
Surrogate directed	40%	45%	the same

**Choices for Care: Use of Personal Care Services by Type, sfy2006-sfy2008**  
**Average Number of Hours of Service per Month**  
**Paid Claims, by Dates of Service (adjusted for biweekly billing cycles)**



Data source: EDS paid claims, by date of service

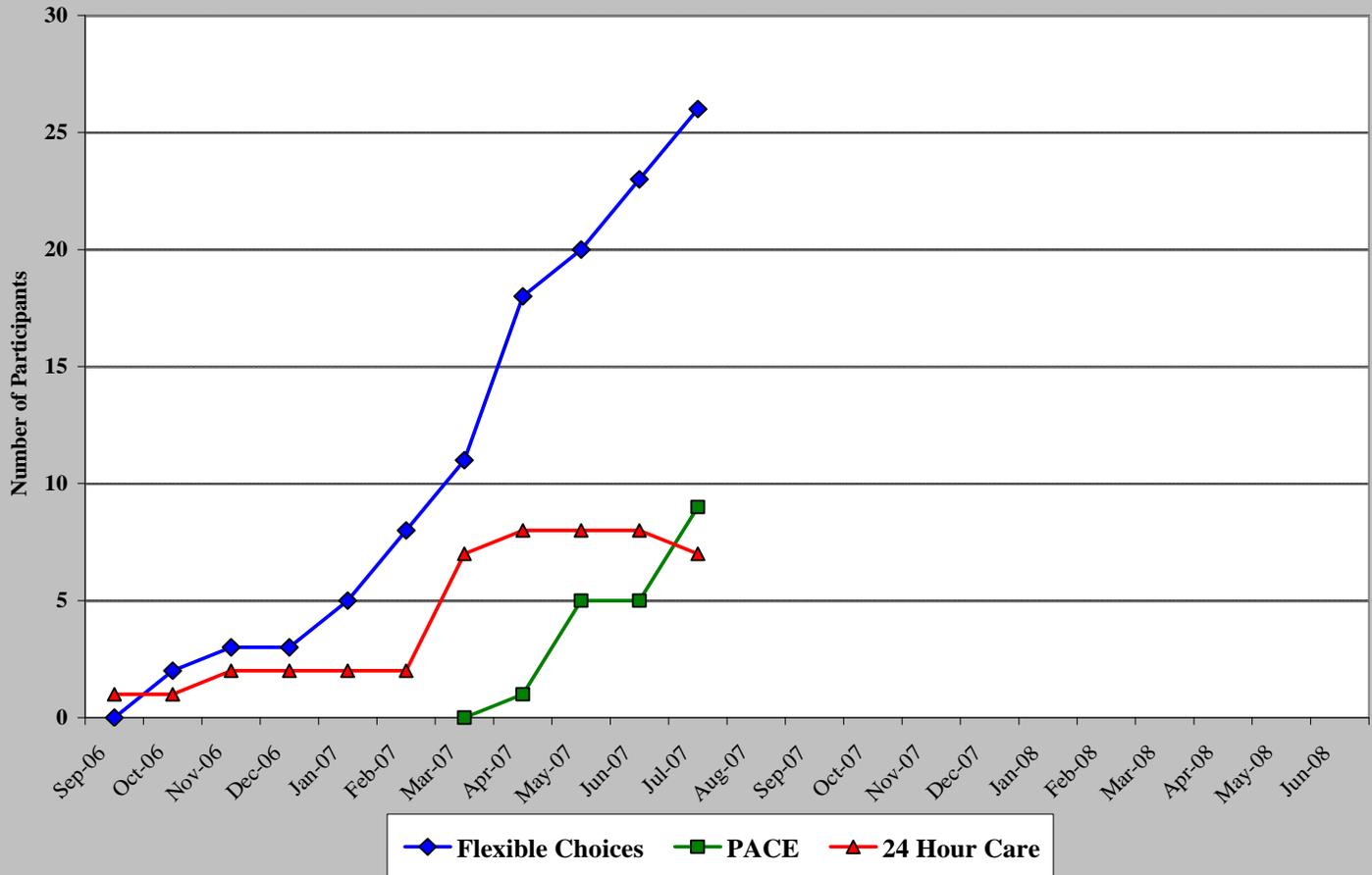
Note: consumer and surrogate directed data adjusted to reflect equal numbers of payperiods in all months

This graph shows the trends in the average number of hours of service that people actually receive each month.

People using consumer and surrogate directed services receive an average of about 140 hours per month, or about 33 hours per week. People using home health agency services receive an average of about 75 hours per month, or about 17 hours per week. Because some people use a combination of services, the average number of hours of all personal care services is about 150 hours per month, or about 35 hours per week.

## Choices for Care: Expansion of New Service Options, sfy2007-sfy2008

### Flexible Choices, PACE, and HCBS 24-Hour Care



Data source: DAIL/DDAS SAMS database

One of the goals of Choices for Care is to expand the range of service options. This graph shows the initial growth in enrollment in three new service options: Flexible Choices, PACE, and HCBS 24-Hour Care.

In May 2007, Choices for Care implemented a policy allowing spouses to be paid to provide personal care, which represents a new service option. However, no process currently exists to track the number of people who use this option.