



Choices for Care

Quarterly Data Report

March 2007

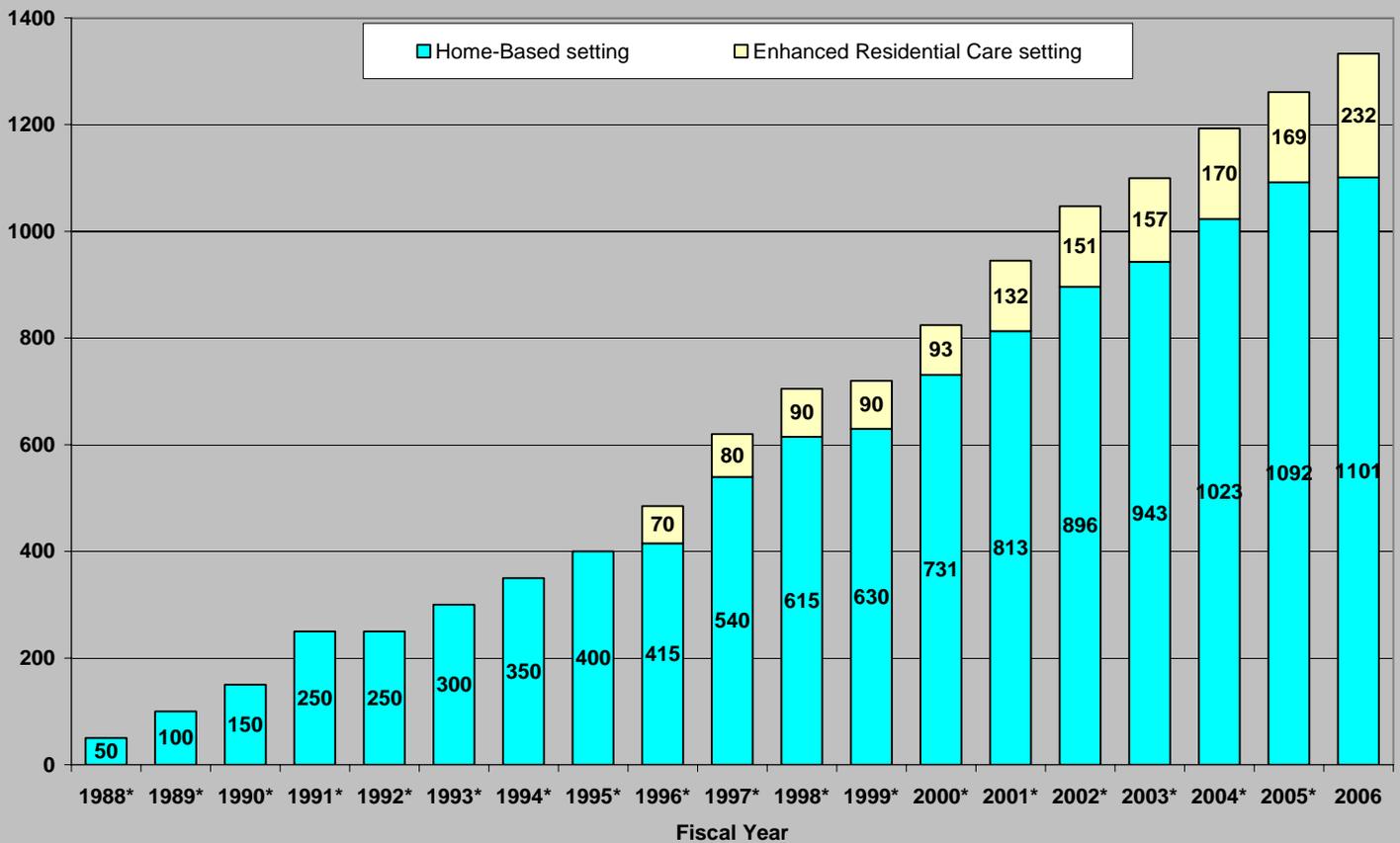
This report documents the status and progress of Choices for Care. This report is intended to provide some useful information regarding the enrollment and service trends within Choices for Care. A brief explanation accompanies each graph, chart or table.

The primary data sources are SAMS Choices for Care enrollment and service authorization data maintained by the Division of Disability and Aging Services, and Medicaid claims data maintained by EDS.

We welcome your comments, questions and suggestions.

Bard Hill, Director
Information and Data Unit
Division of Disability and Aging Services
Department of Disabilities, Aging and Independent Living
Agency of Human Services
103 South Main Street – Weeks Building
Waterbury, Vermont
05671-1601
802.241.2335
TTY 802.241.3557
Fax 802.241.4224
<http://dail.vermont.gov>

**Numbers of People Served in Aged/Disabled Medicaid Waivers
Maximum Number Within Year, sfy1988-sfy2006**
(does not include moderate needs group)

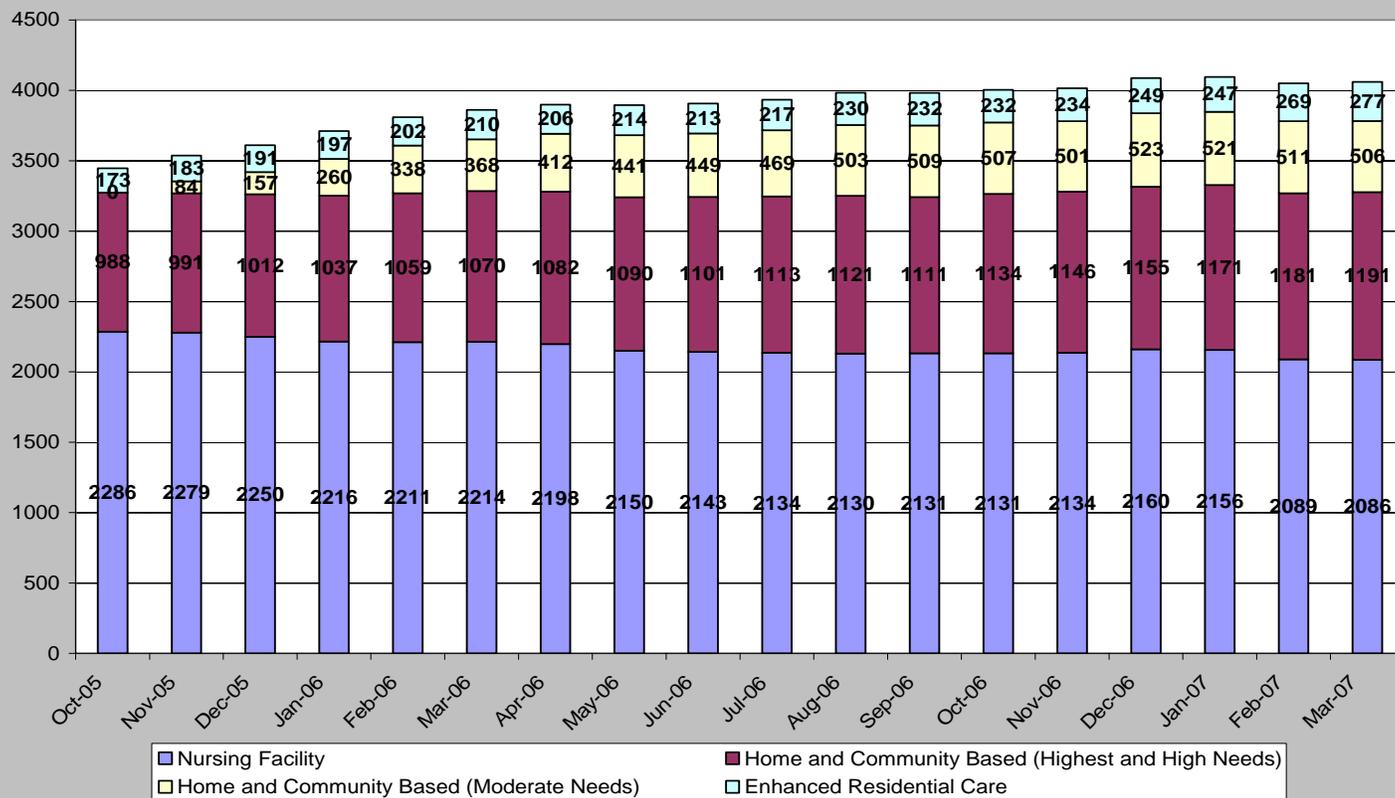


* years preceding Choices for Care, with limited funding and enrollment

This graph documents the controlled growth in home and community based services in Vermont 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 forced to wait for funding to become available.

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

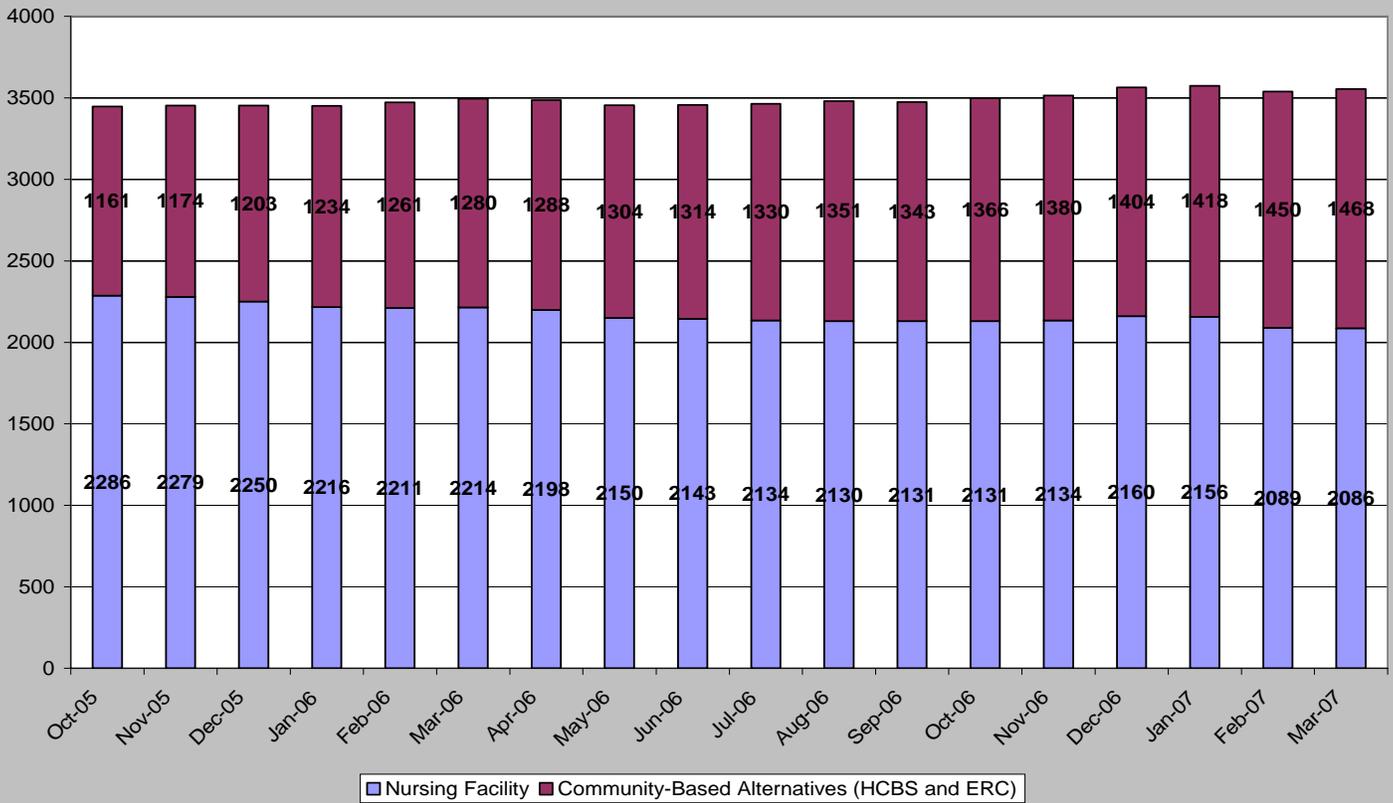


Data source: DAIL/DDAS SAMS database.

This shows the number of participants enrolled in each Choices for Care setting since the entitlement to all settings was created (October 2005). The number of people served in nursing homes has continued to decrease over time, 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 under Medicaid decreased by 200 (from 2,286 to 2,086) between October 2005 and March 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 203 (from 988 to 1,191) between October 2005 and March 2007.
3. Enhanced Residential Care: the number of people increased by 104 (from 173 to 277) between October 2005 and March 2007. Some people transitioned to ERC settings from the TBI Waiver and from Morrisville Center nursing home.
4. HCBS Moderate Needs Group: the number of people in this ‘expansion’ group increased from 0 to 506 between October 2005 and March 2007.

Choices for Care: Total Number of Enrolled Participants
October 2005 - March 2007
(excludes moderate needs group)



Data source: DAIL/DDAS SAMS database.

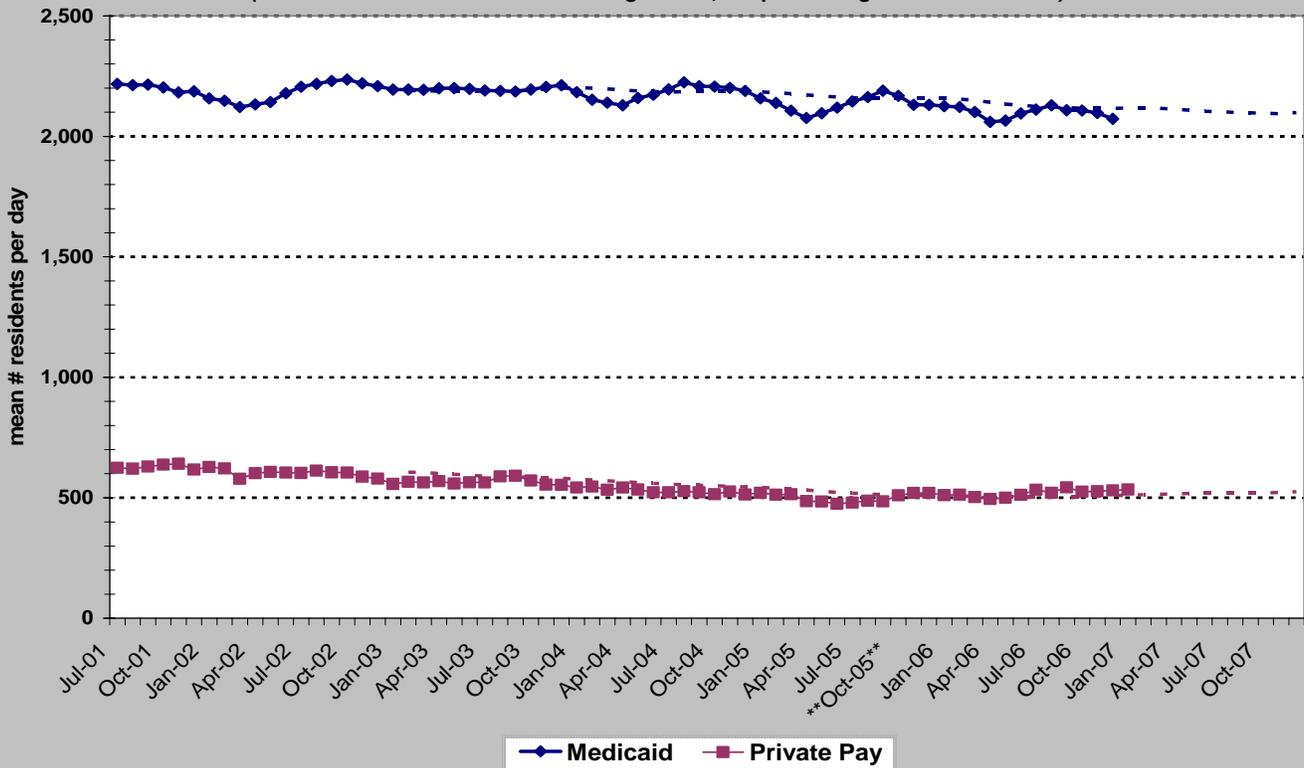
This shows the trends in enrollment of people in the Highest Needs Group and the High Needs Group, who meet the traditional nursing home eligibility criteria.

Over the course of 18 months, the total number of people enrolled in these two groups has grown modestly. The total number served increased by about 100 people (or about 3%). Prior to Choices for Care, the annual increase in the number of people served in HCBS and ERC was also about 100. This suggests that initial concerns about a ‘woodwork effect’, in which large numbers of new people would enroll in Medicaid long term care services and cause unexpected cost increases, were unfounded.

This modest growth in the total number of people masks a shift in enrollment between the service settings. The number of people served in the HCBS and ERC settings has increased by about 300, while the number of people served in nursing home settings has decreased by about 200. The core hypothesis of Choices for Care seems to be supported- in offering an entitlement to community-based care, the number of people who choose nursing homes has decreased, which frees funding to serve more people in the community.

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

(data source DRS- out of state nursing homes, hospital swing beds not included)



Oct-05 : beginning of Choices for Care

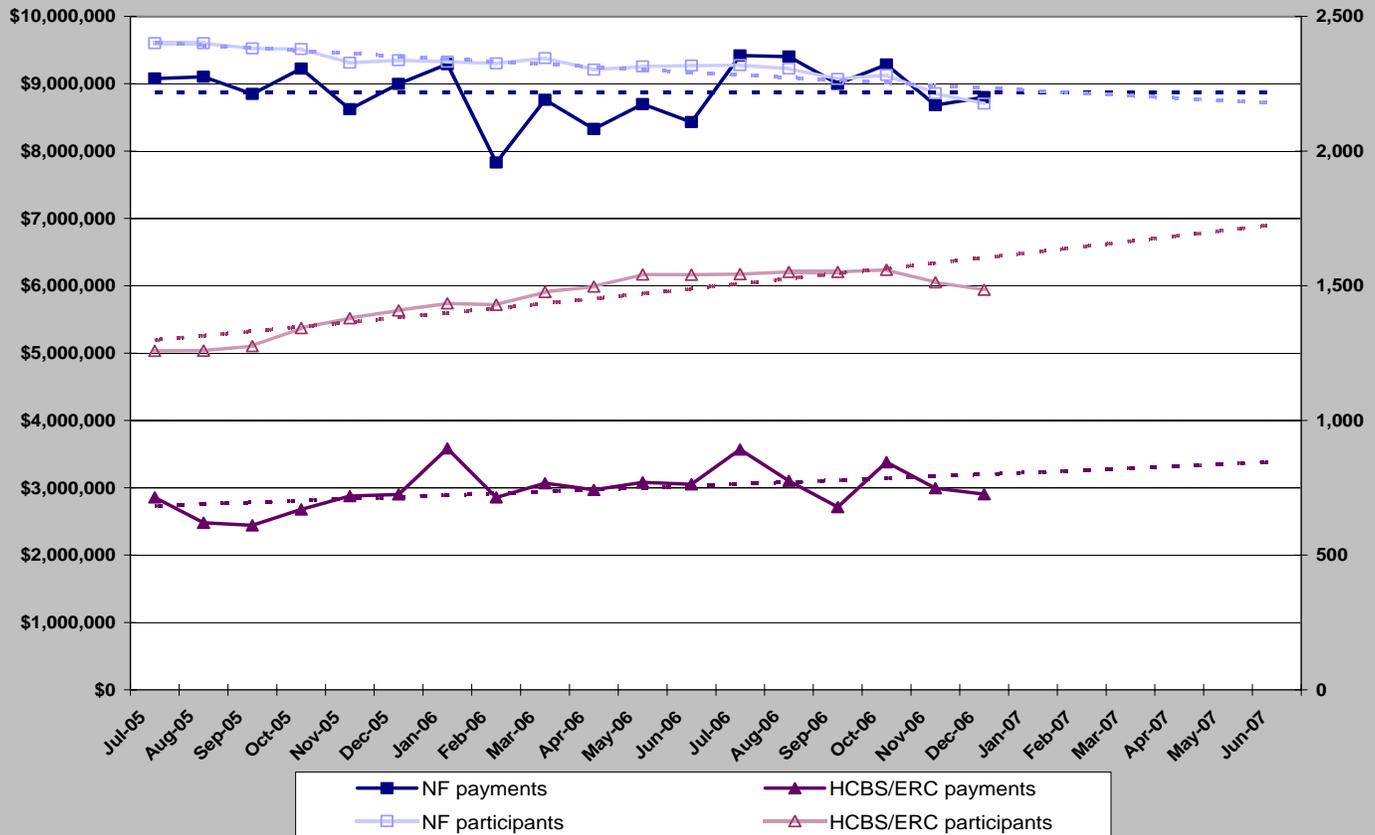
Data source: Agency of Human Services Division of Rate Setting, reported resident days by month.

This shows trends in nursing home use over time for people whose primary payor was Medicaid and for people who paid privately. These average occupancy figures are computed from total monthly ‘resident days’ reported by Vermont nursing homes to the Division of Rate Setting.

Consistent with other data sources, this shows that the number of Medicaid nursing home residents has continued to decrease over time. Note that nursing home closings and other reductions in the number of licensed beds contribute to this decrease. If recent trends continue, the number of Medicaid nursing home residents will continue to decrease.

The number of private pay residents decreased between 2001 and 2005, but has increased slightly since then. A number of factors may contribute to this change, including more restrictions on transfers of assets under revised long term care Medicaid eligibility rules.

Vermont Long Term Care Payments and Participants by Setting, sfy2006-sfy2007
excludes moderate needs group



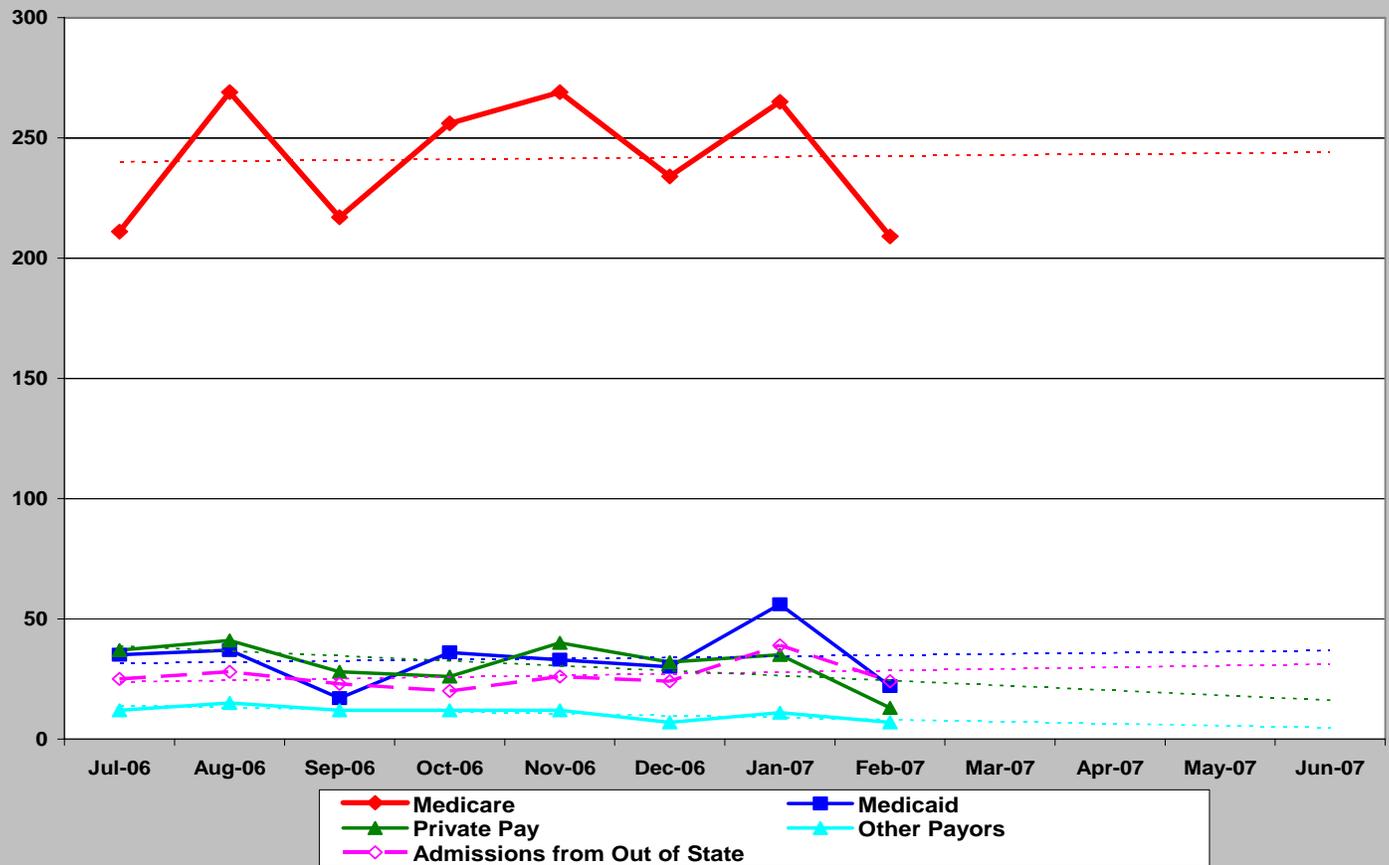
Data source: EDS Medicaid paid claims, by date of service.

This shows trends in the use of nursing homes and in the use of nursing home alternatives (HCBS and ERC). The graph uses Medicaid paid claims data, including both the numbers of people served within each month and the dollars paid for their services.

The number of people served in nursing homes has decreased modestly, while nursing home payments have remained roughly level. The number of people served in HCBS/ERC settings has increased significantly, while payments for these services have increased at a more moderate rate.

If recent trends continue for the next several years, the number of people served in HCBS and ERC may surpass the number of people served in nursing homes.

Admissions to Vermont Nursing Homes by Type by Month, SFY07



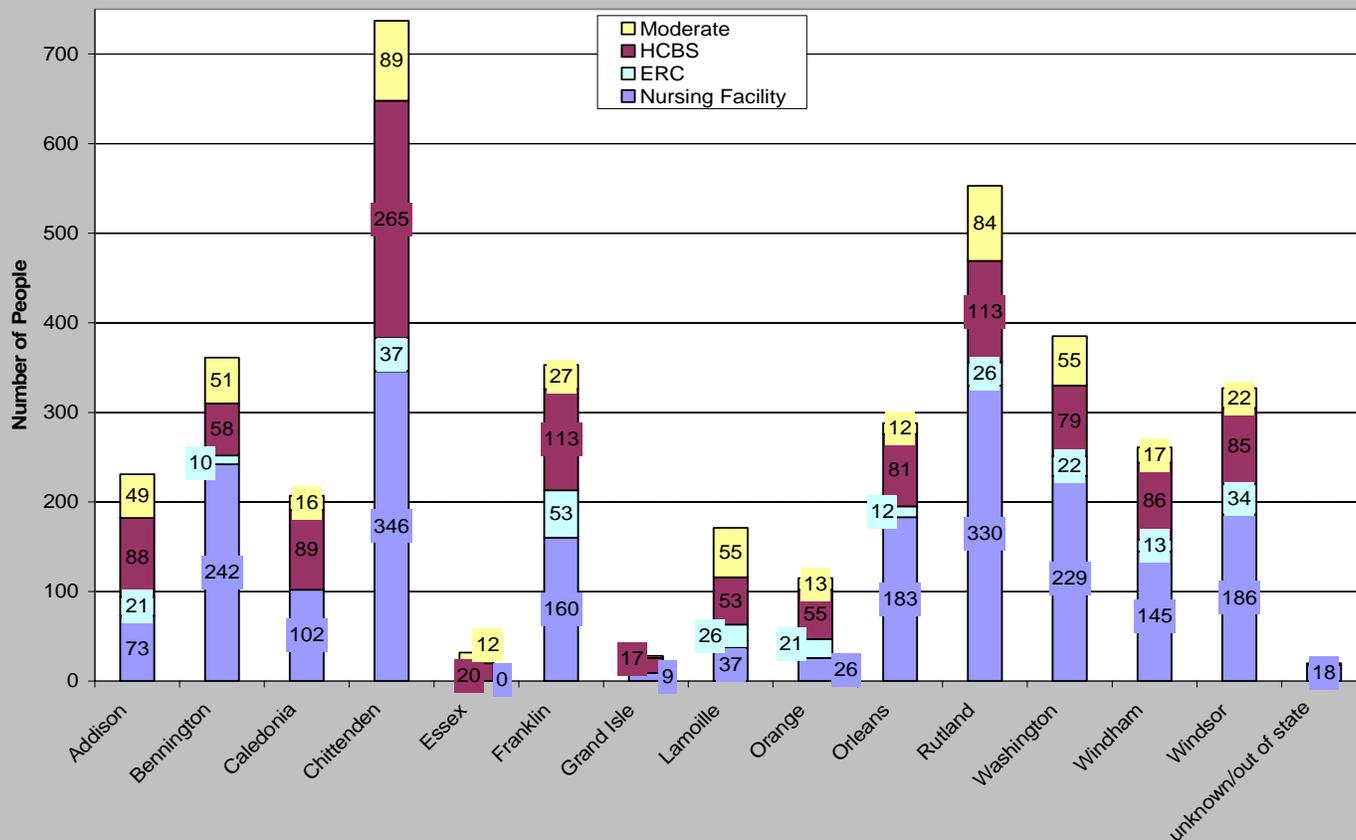
Data source: DAIL Division of Licensing and Protection

This shows recent trends in admissions to nursing homes in Vermont, as reported by providers to the DAIL Division of Licensing and Protection.

Medicare admissions represented the majority of admissions, averaging 241 people per month (76% of all admissions). Both Medicaid and private pay admissions averaged about 32 admissions per month (10% of all admissions). Note that many people convert to Medicaid after they are admitted to a nursing home, which explains why more than 60% of nursing home days in Vermont have Medicaid as the primary payor source.

The graph also shows the number of people who were admitted to Vermont nursing homes from other states. Including all payor sources, an average of about 26 people were admitted from other states each month. While 27 nursing homes admitted at least one person from another state, only 5 nursing homes admitted more than 10 people from other states: Center for Living (56), Bennington Health and Rehabilitation Center (24), Crescent Manor (17), Vermont Veteran’s Home (14), and Brookside/White River Junction (11). Four of these nursing homes are in Bennington County, which represented more than half of all admissions from other states.

Choices for Care: Enrolled Participants by Setting by County as of March, 2007



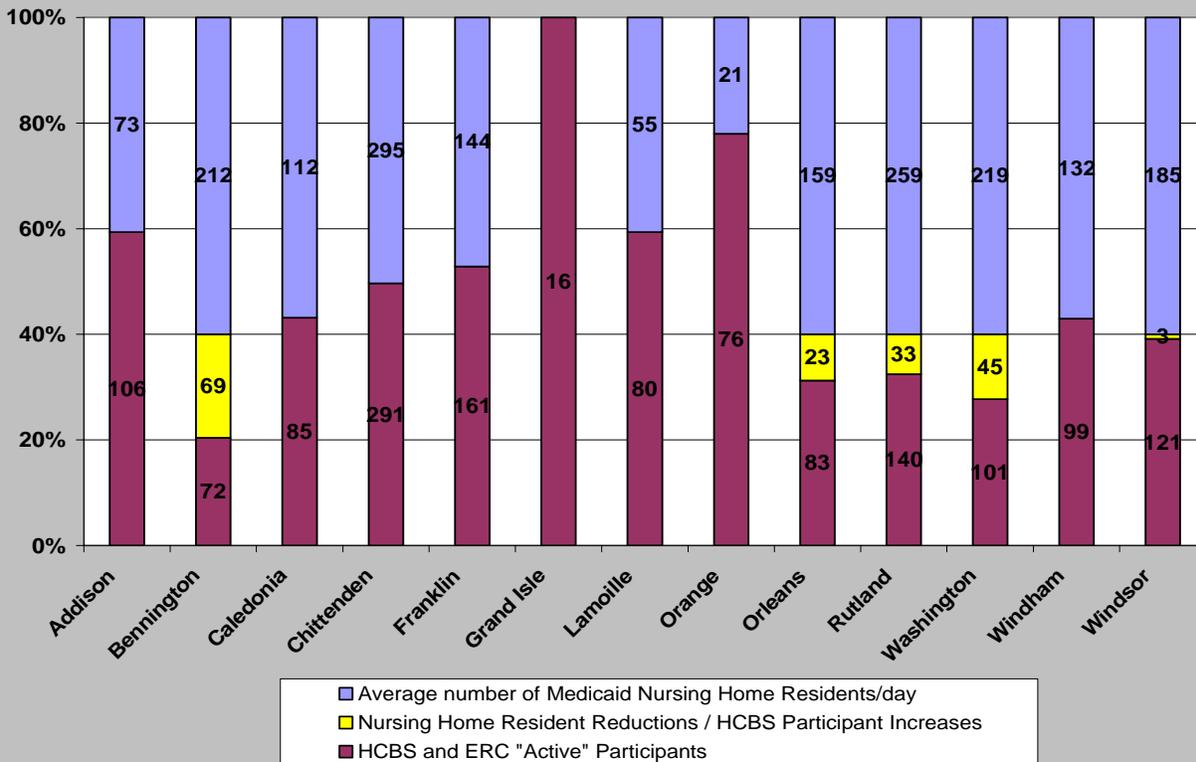
Data source: DAIL/DDAS SAMS database.

This shows the settings in which Choices for Care participants are served within each 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.

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



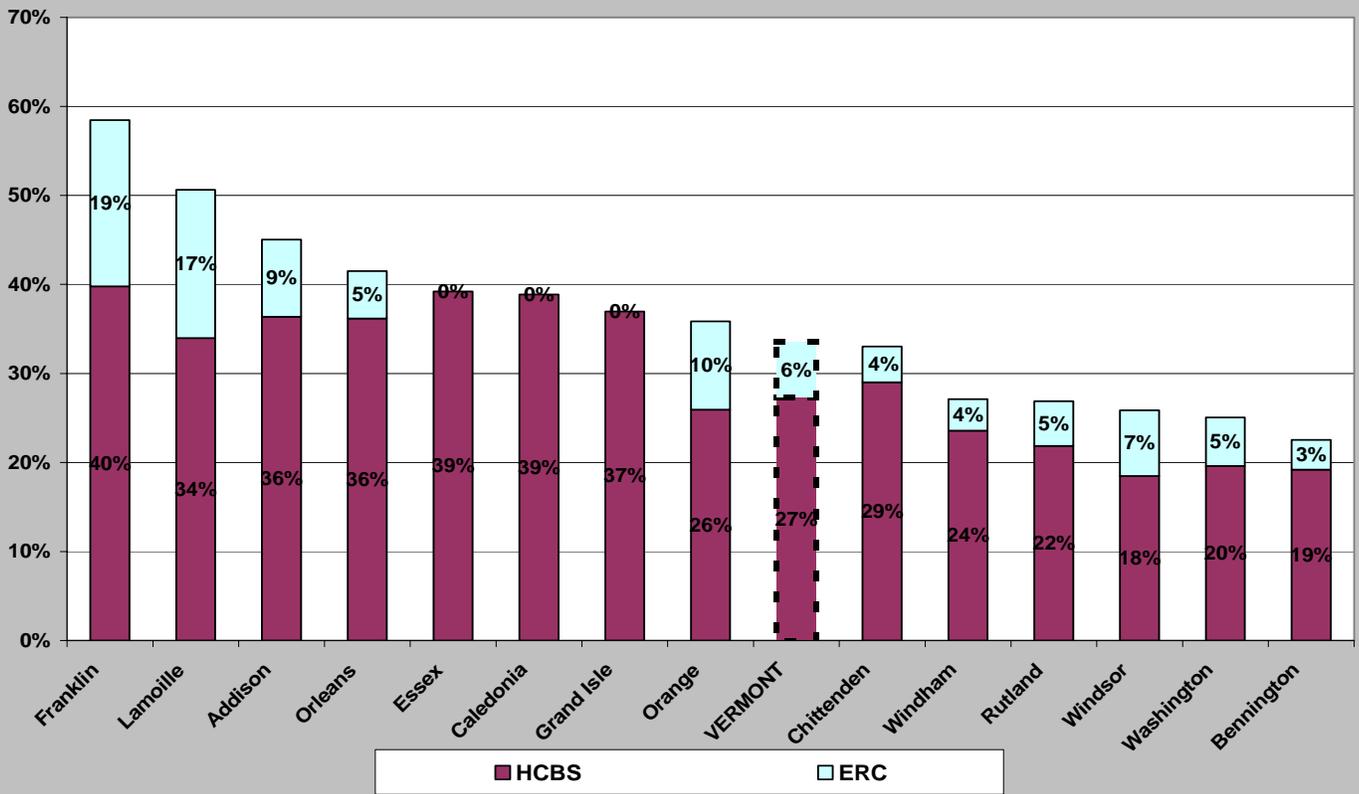
Data sources: DAIL/DDAS SAMS database; Division of Rate Setting.

One of the goals of Choices for Care is to serve a higher percentage of people using Medicaid-funded long term care in community settings, i.e. outside of nursing homes. This graph illustrates our status in achieving this goal as of January 2007, by county. The graph shows the percentage of Choices for Care participants who were served in nursing home settings (blue), the percentage served in alternative settings (red), and the percentage who would have to move from a nursing home setting to an alternative setting to reach a threshold of 40% in the alternative settings (yellow).

In Addison, Franklin, Grand Isle, Lamoille, and Orange Counties, more than 50% of Choices for Care participants are served in alternative settings. Note that reductions in the number of nursing home beds (e.g. the recent closing of Morrisville Center in Lamoille County) can have a direct effect on this balance.

In Caledonia, Chittenden, and Windham Counties, at least 40% of participants are served in alternative settings. Windsor County is also very close to reaching the 40% threshold. People in the remaining counties - Bennington, Orleans, Rutland, and Washington- remain more dependent on nursing homes, with less than 40% served in alternative settings.

Choices for Care: People Served in HCBS and ERC as a Percentage of Estimated Number of People with Disabilities (2+ ADLs) by County - March, 2007
Aged 18+, all income groups, excluding people with mental retardation/developmental disabilities



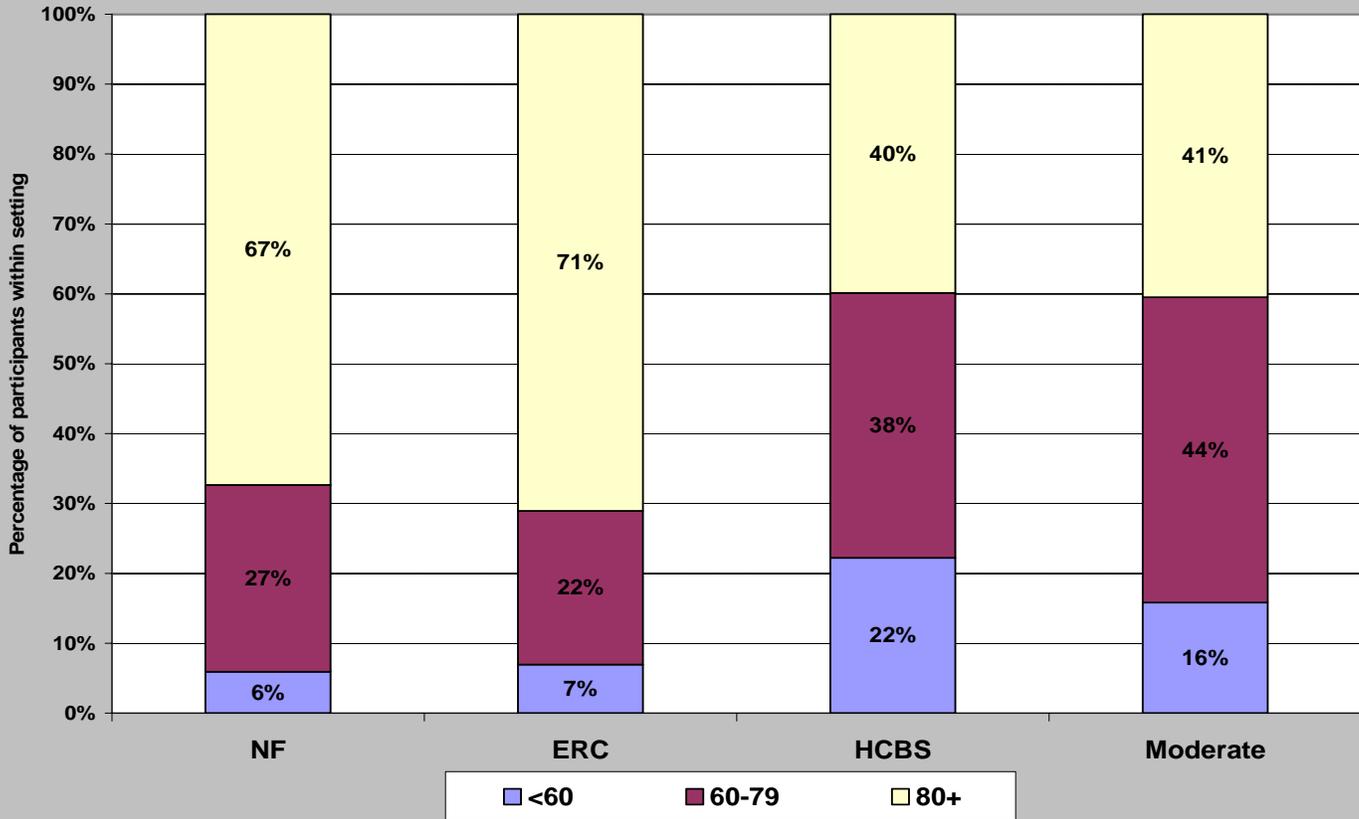
Data sources: DAIL/DDAS SAMS database; *Shaping the Future of Long Term Care and Independent Living, draft 2007.*

This graph provides a different view of the use of services by county. It represents one method of looking at HCBS and ERC service utilization based on population, separate from nursing home use. In the previous graph, the ‘balance’ of alternative services is affected by the number of people served in other settings (e.g. the closing of a nursing home). This graph avoids this, showing the use of alternate settings as a percentage of the estimated number of people who need these services.

The Department’s yearly report, *Shaping the Future of Long Term Care and Independent Living*, uses a demographic formula to estimate the number of people in each county who need community-based long term care services. ‘Need’ is defined as requiring assistance with two or more activities of daily living. This graph uses this definition of need for all people aged 18 and over, in all income groups, as an estimate of 100% of each county’s need. While it is not reasonable to conclude that 100% of the people should be served, this does provide a method of comparing service use in different counties.

Franklin, Lamoille, Addison, Orleans, Essex, Caledonia, Grand Isle, and Orange Counties are now meeting a high percentage of estimated demographic need with HCBS and ERC. Chittenden County is close behind this group. Windham, Rutland, Windsor, Washington, and Bennington Counties meet a lower percentage of demographic need with HCBS and ERC. These county patterns are similar to the patterns found in other data sources.

Choices for Care: Active Participants by Setting by Age, March 2007



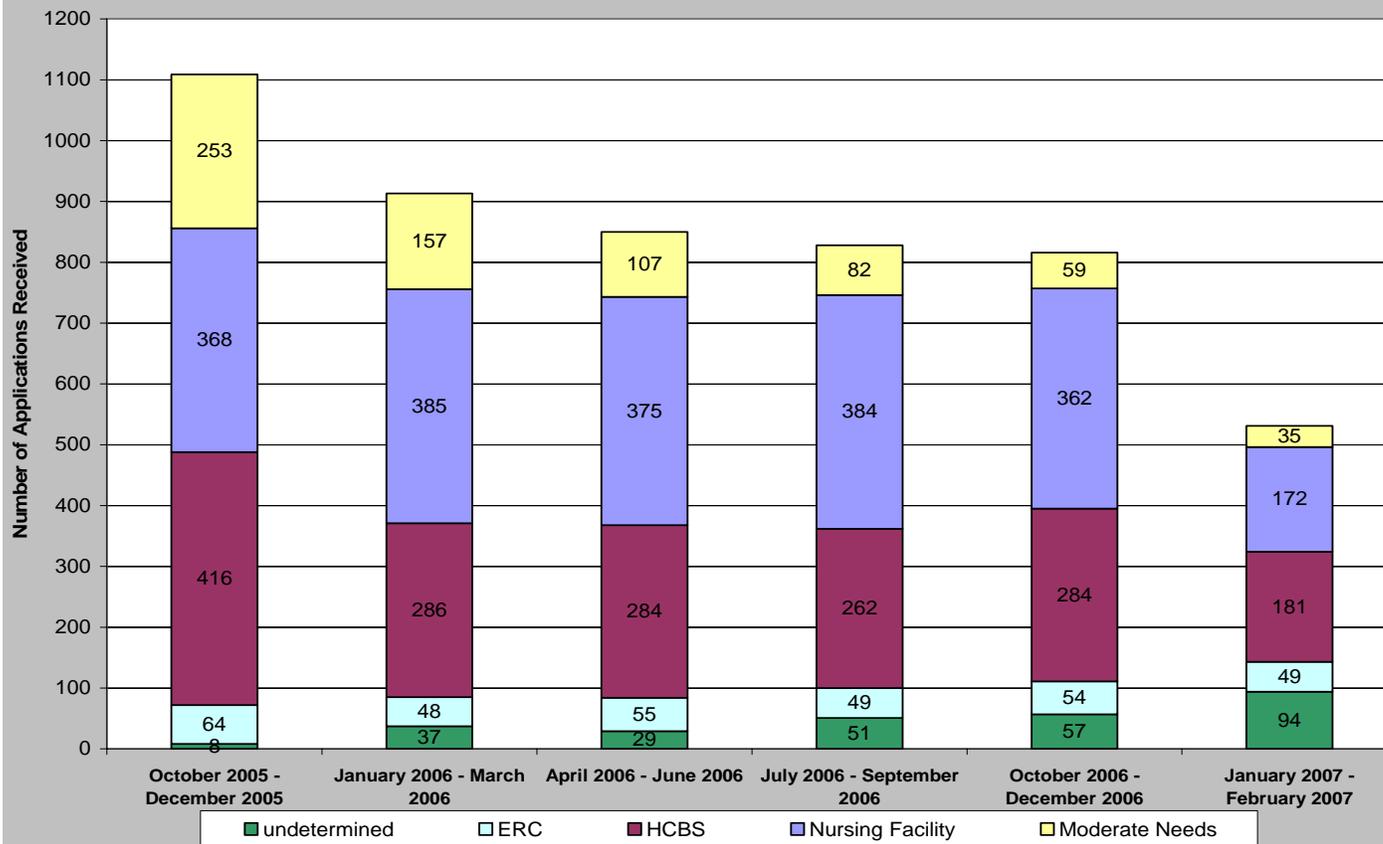
Data source: DAIL/DDAS SAMS database.

This graph shows the age distribution of participants within four groups of participants (Nursing Facility, Enhanced Residential Care, Home and Community Based Services, and Moderate Needs Group). Overall, 56% of Choices for Care participants are aged 80 or older; 32% are aged 60-79, and 12% are under the age of 60. The highest percentage of people aged 80 and over is found in the ERC setting, closely followed by the NF setting. The highest percentage of people under the age of 60 is found in the HCBS setting.

The median age of people enrolled in the HCBS Highest/High Needs Groups is nearly 80. Due to the larger numbers of older people enrolled in Choices for Care, people over the age of 80 outnumber younger people in every service option. However, many younger people are also served in Choices for Care- including about 100 people under the age of 40, and about 160 people aged 41-50.

	NF		ERC		HCBS		Moderate	
	#	%	#	%	#	%	#	%
Age < 60	123	6%	19	7%	267	22%	81	16%
Age 60-79	555	27%	60	22%	455	38%	223	44%
Age 80+	1398	67%	194	71%	479	40%	207	41%
Total	2076		273		1201		511	

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

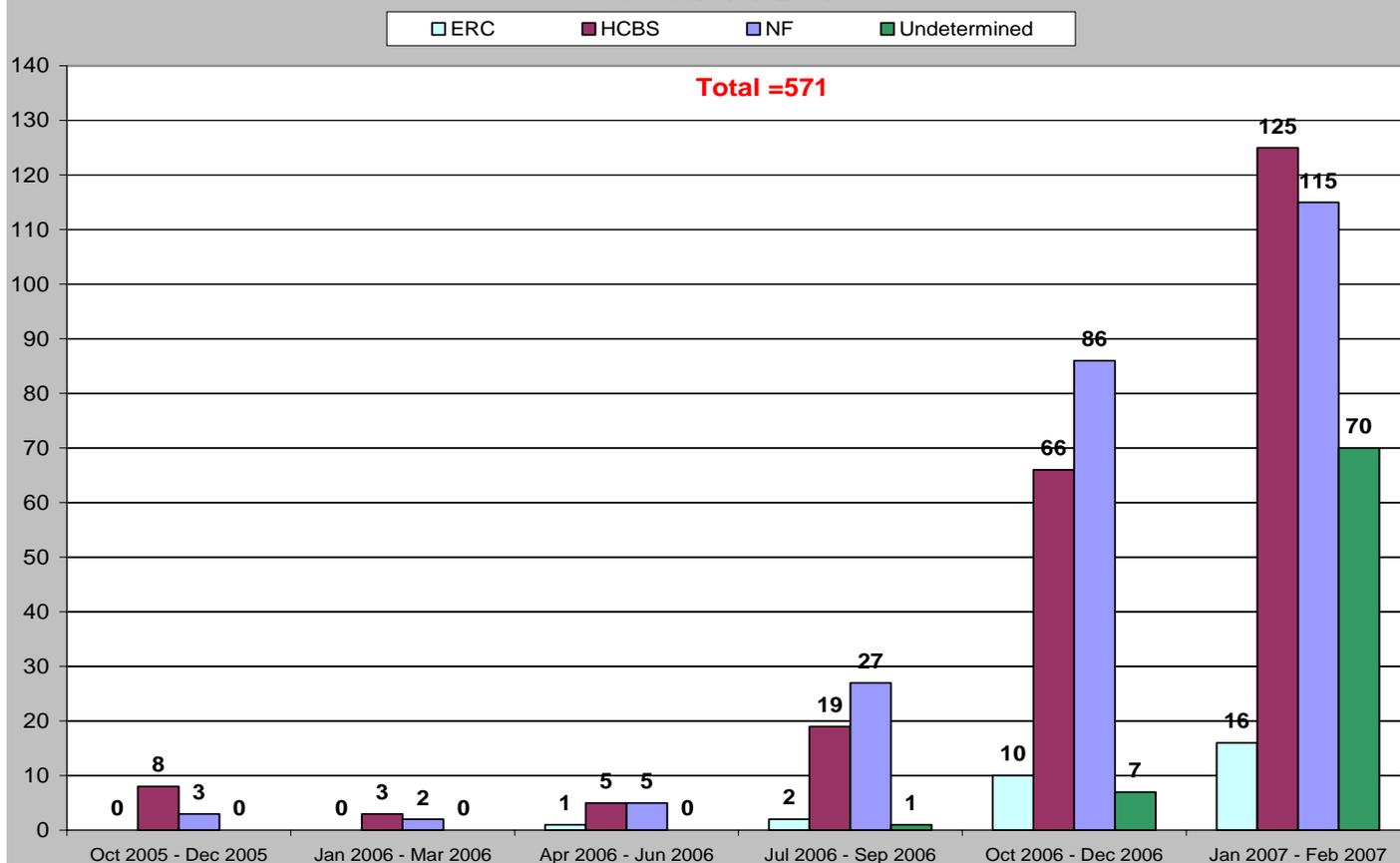


Data source: DAIL/DDAS SAMS database.

This graph shows the numbers of Choices for Care applications received over time, by setting. This is useful in representing changes in overall ‘demand’ over time, as well as measuring staff workload associated with processing applications in 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 2005. In subsequent months, the number of applications has stabilized. DAIL/DDAS receives a total of about 260 applications each month. Nearly half of the applications received are for Nursing Facilities (including short-term and rehabilitation nursing home admissions under Medicaid.) About 35% of the applications are for Home and Community Based Services, and about 7% are for Enhanced Residential Care.

**Choices for Care: Pending and Received Applications by Date of Application
October 2005 through February 2007
as of March 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. One indicator of our success in achieving this goal is processing individual applications in a timely manner.

This graph shows the quarters in which pending Choices for Care applications were received. While many applications are fully processed within eight weeks, a small number remain pending for many months due to delays in Medicaid eligibility.

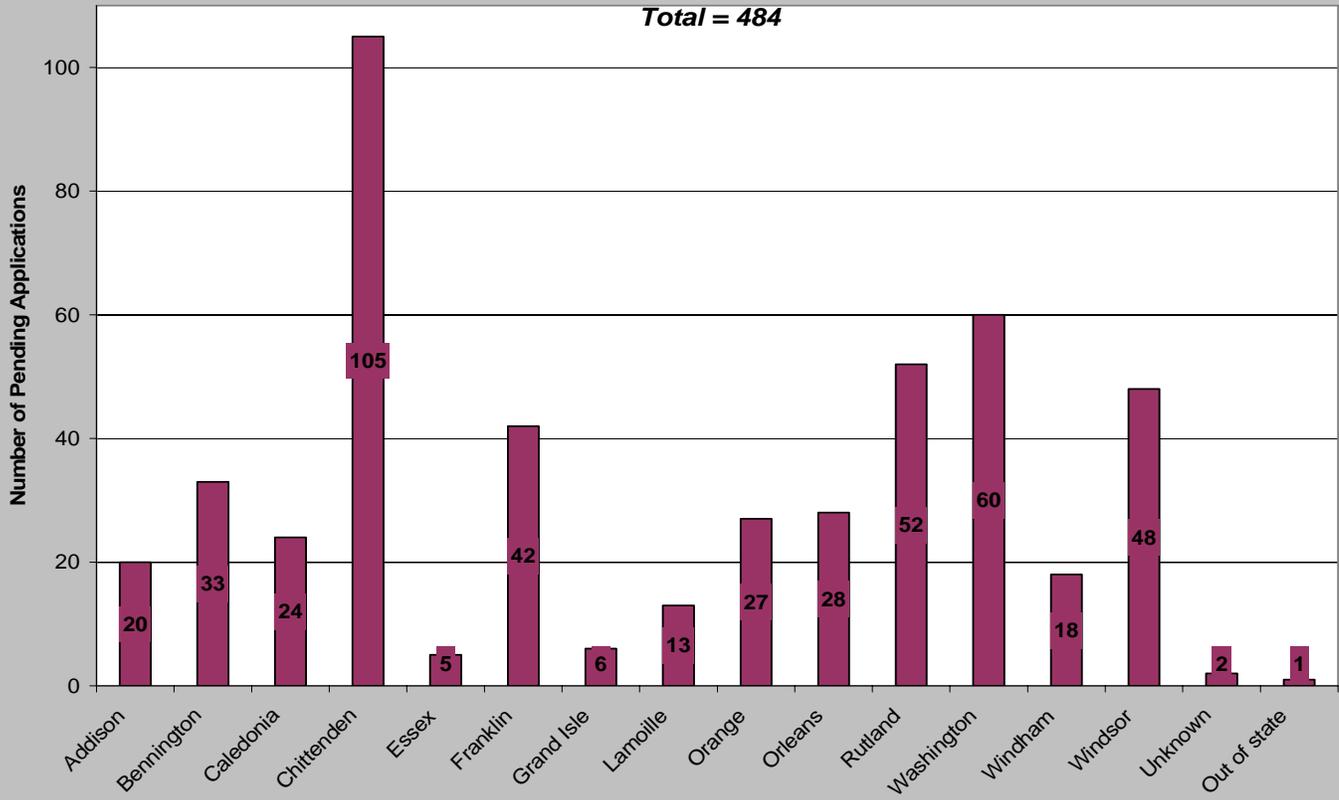
Common causes for delays in Medicaid eligibility include:

1. Long-term care Medicaid applications are not 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 together to find ways to process applications as quickly as possible. The co-location of staff in regional offices seems to contribute to effective communication and timely processing of applications.

Choices for Care: Pending/Pending Medicaid Applications by County, March 2007

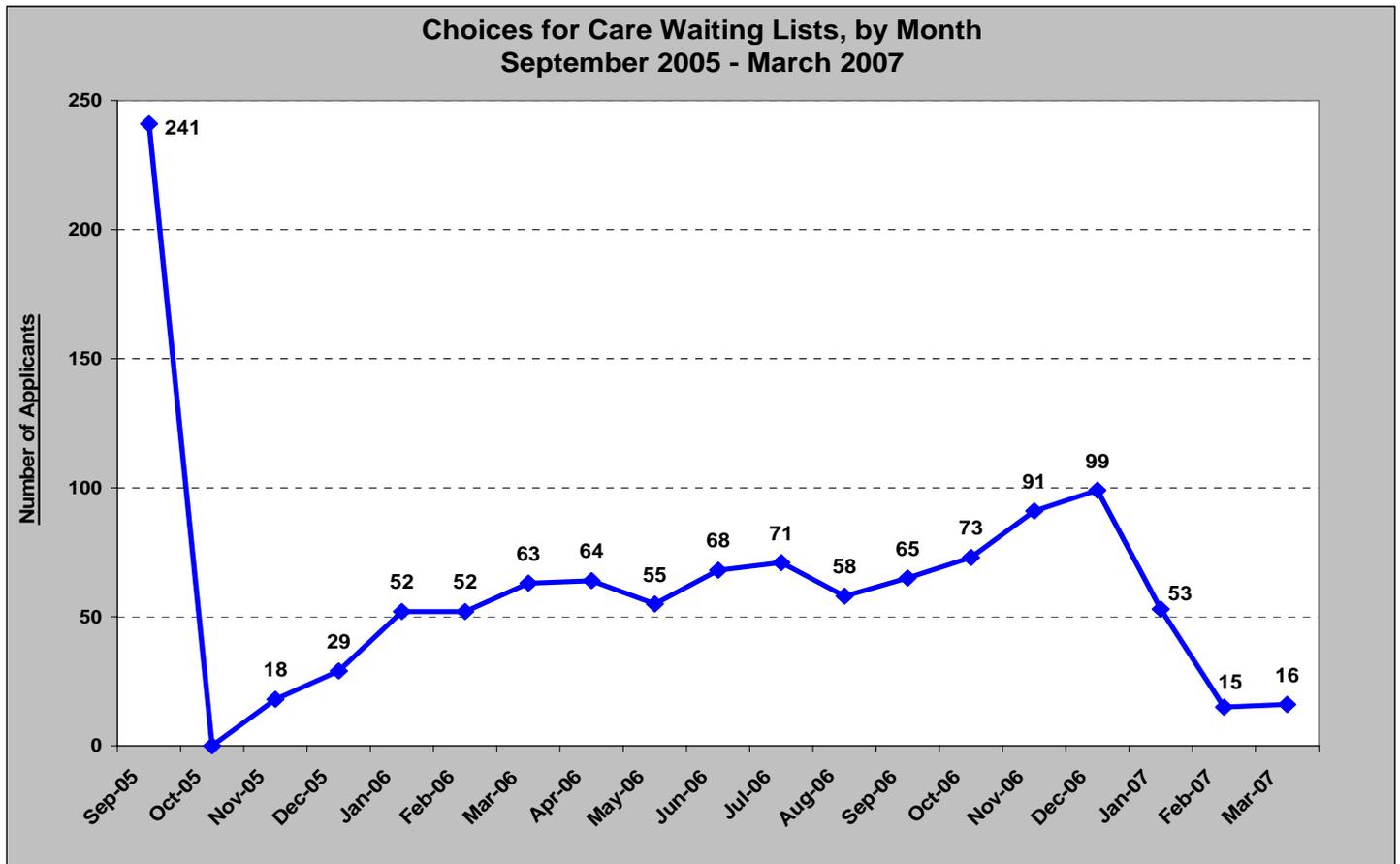
Total = 484



Data source: DAIL/DDAS SAMS database.

The number of pending applications can be used as one indicator of success in ensuring timely access to services across Vermont. It also serves as an indicator of ongoing staff workload within each county.

While the number of pending applications is related to the size of the county's population, this relationship is not consistent across the state. Chittenden has many more pending applications than any other county- nearly twice as many as Washington, the county with the next highest number.



Data source: DAIL/DDAS SAMS database.

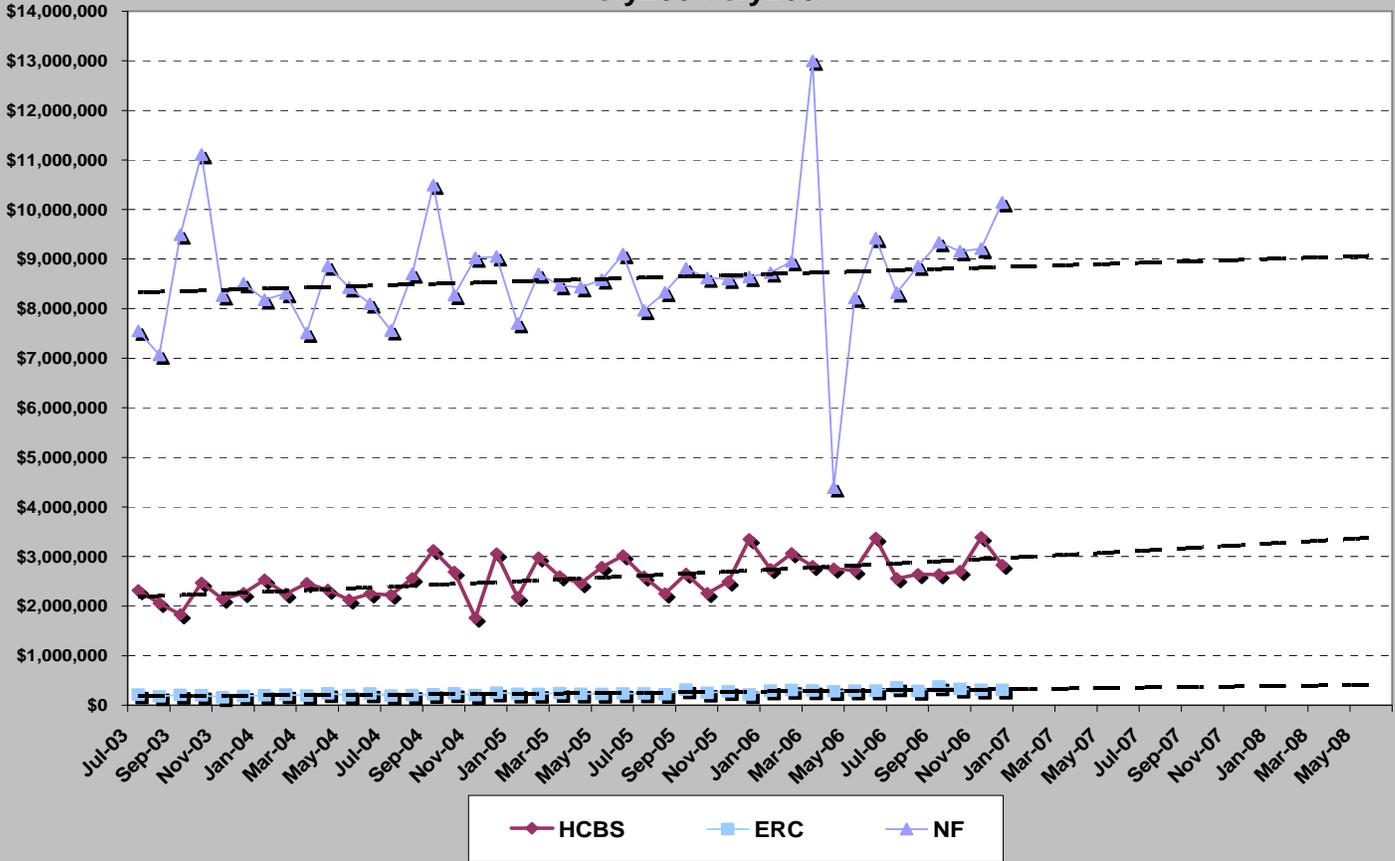
Prior to the implementation of Choices for Care, access to Home and Community Based Services and Enhanced Residential Care were limited by available funds, and many applicants were routinely placed on waiting lists. The total number of people on waiting lists fell substantially when Choices for Care was implemented in October 2005, when all applicants who met 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.

Some people from the waiting list were admitted under special circumstances or because their needs increased so that they met the Highest Needs Group eligibility criteria. This includes 41 people admitted to Home and Community Based Services, 2 people admitted to Enhanced Residential Care, and 2 people admitted to nursing facilities.

Based on the availability of funds, limited numbers of people from the High Needs Group waiting list were enrolled in Choices for Care during July 2006 and December 2006. Under recent legislative direction, all High Needs Group applicants will be enrolled through the remainder of SFY 2007.

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



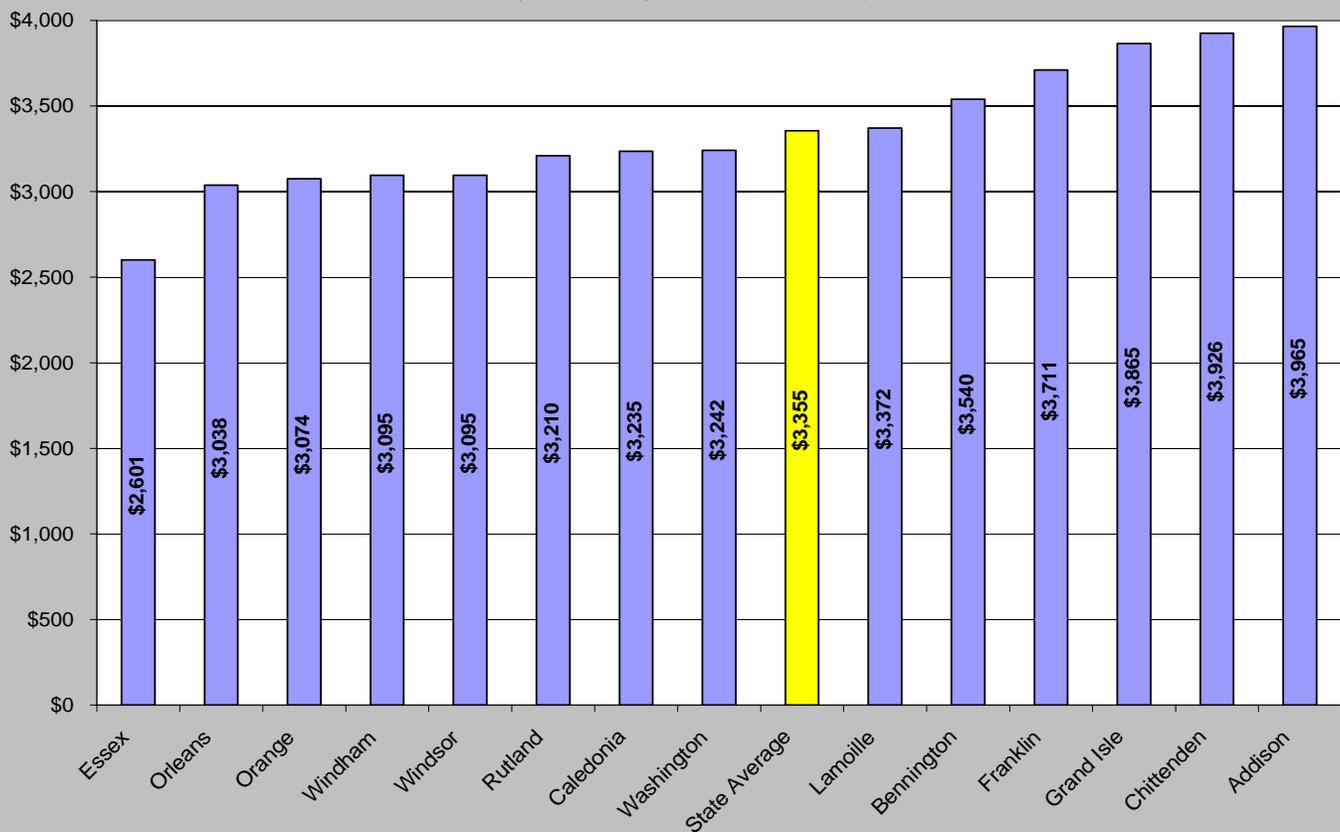
Data source: DAIL Monthly Monitoring Report.

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 74% of total expenditures. Home and Community Based Services (HCBS) expenditures represent about 23%, and Enhanced Residential Care expenditures represent about 3%.

Enhanced Residential Care expenditures have increased the most rapidly, increasing 55% since 2003. In the same time period, Home and Community Based Services expenditures have grown 37%, and Nursing Facilities expenditures have grown 8%.

Choices for Care: Average Monthly Cost of Approved HCBS Plans of Care by County, March 2007
(Highest and High Needs Groups only)



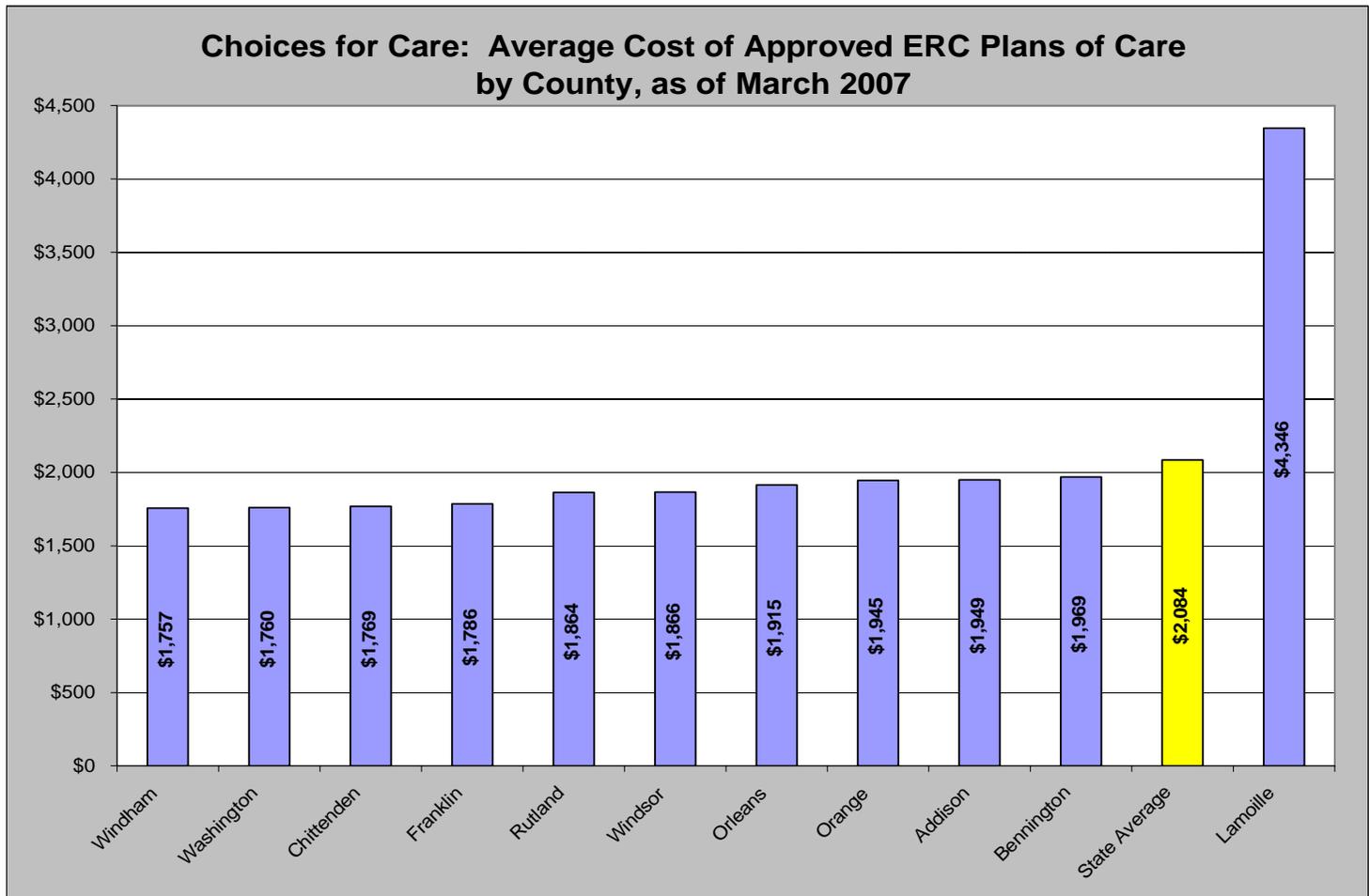
Data source: DAIL/DDAS SAMS database.

The average approved cost of HCBS Highest/High Needs Group Plans of Care was \$3,355. The average costs in Chittenden, Grand Isle, and Addison Counties were well above the state average. The average cost in Essex County was well below the state average.

The available evidence suggests that several factors contribute to these higher costs, including:

1. Greater use of Home Health Agency personal care services, at a higher reimbursement rate.
2. Higher volumes of personal care services.
3. Greater use of adult day services.
4. Lower use of home health services (nursing and licensed nurse assistants) supported by Medicare or Medicaid.
5. Use of 24-hour care services under HCBS.

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



Data source: DAIL/DDAS SAMS database.

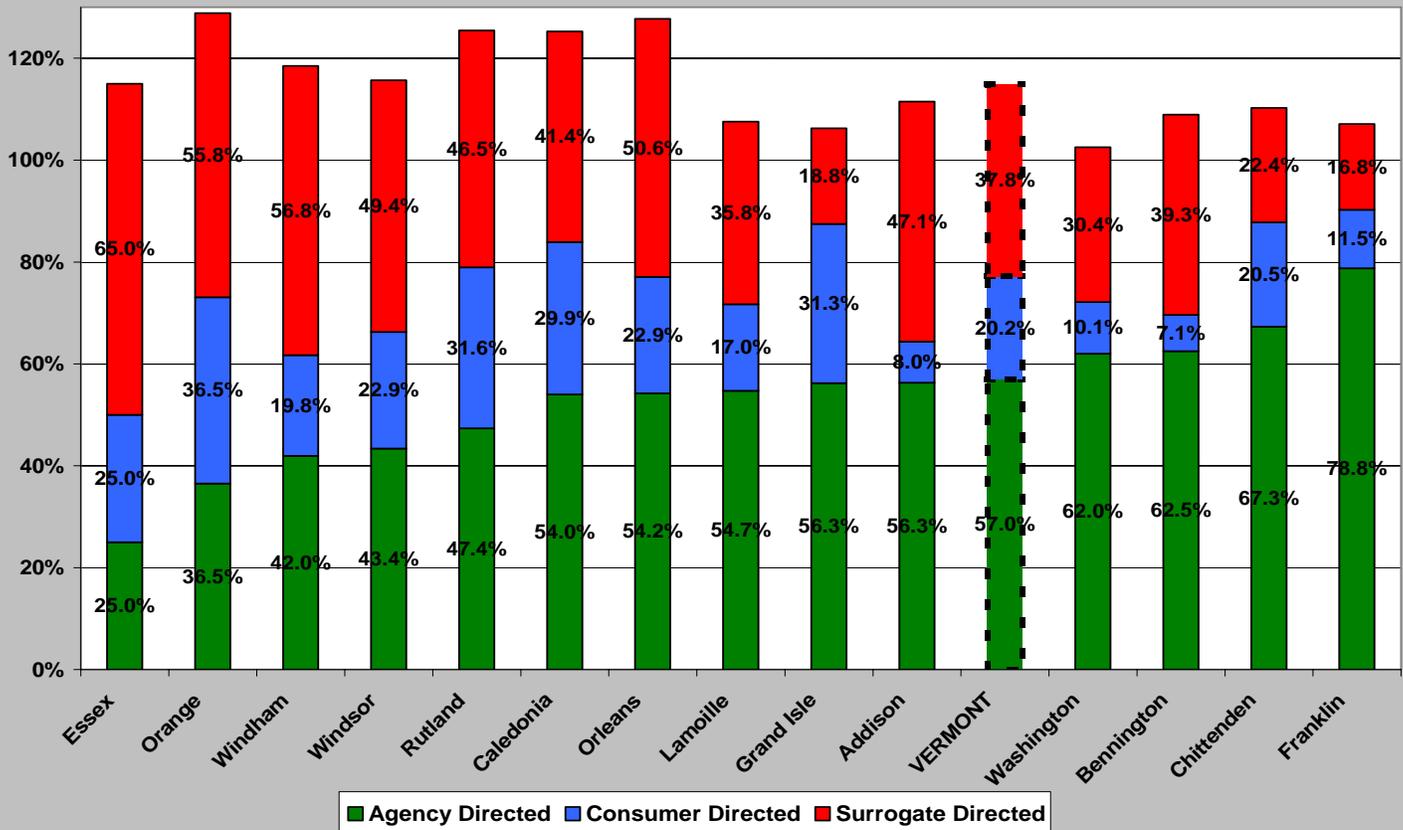
The average approved cost of ERC Highest/High Needs Group plans of care was \$2,084. This is nearly 40% less than the average approved cost of HCBS plans of care.

The highest costs were found in Lamoille County, resulting from special rates paid to ERC providers who provide services to people who were discharged from Morrisville Center nursing home and the Traumatic Brain Injury Program.

There is no consistent relationship between approved HCBS costs and approved ERC costs by county. Addison and Bennington counties 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: Percentage of Active Participants Approved to Use Each Type of Personal Care Service, by County
March 2007**



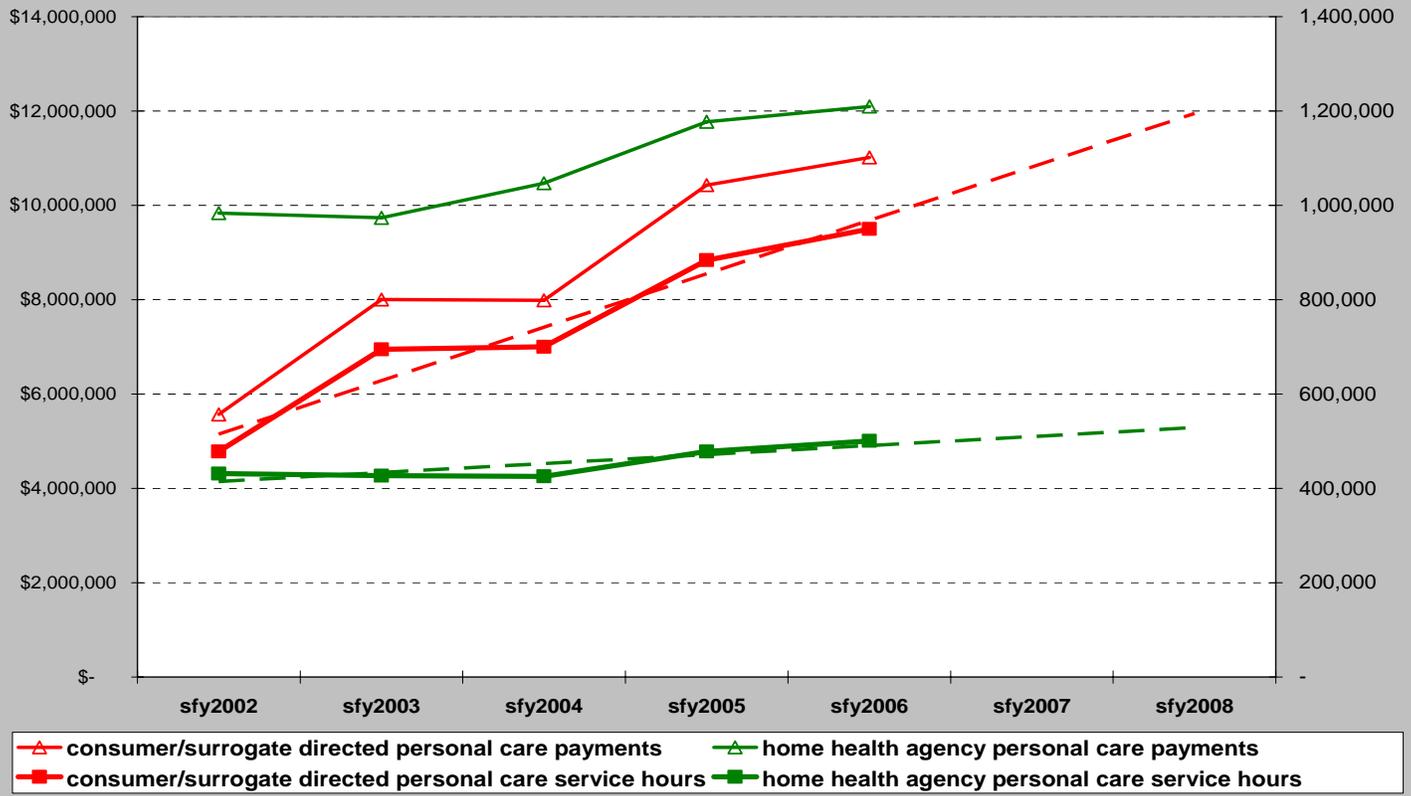
Data source: DAIL/DDAS SAMS database. Includes people who receive more than one type of personal care service.

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 shows what services people were approved to use, not what they actually did use.

Statewide, about 57% of people had service plans that included some home health services, and about 58% had plans that included consumer or surrogate directed services. In every county, significant numbers of people had plans with each type of service. However, there are significant variations among the counties. In some counties a modest percentage of people had service plans with consumer/surrogate directed services, while a high percentage of people had service plans with home health services: Franklin (78.8%), Chittenden (67.3%), Bennington (62.5%), and Washington (62.0%). In other counties a modest percentage of people had service plans with home health services, while a high percentage of people had plans with consumer or surrogate directed services: Essex (90%), Orange (92.3%), Windham (76.5%), Windsor (72.3%), Rutland (78.1%), Caledonia (71.3%), and Orleans (73.5%).

About 15% of the people were approved to use combinations of home health agency services and consumer-directed services, or home health agency services and surrogate-directed services. Because of this, the totals are higher than 100%.

Vermont Long Term Care Personal Care Services: Payments and Units of Service by Type, sfy2002-sfy2006

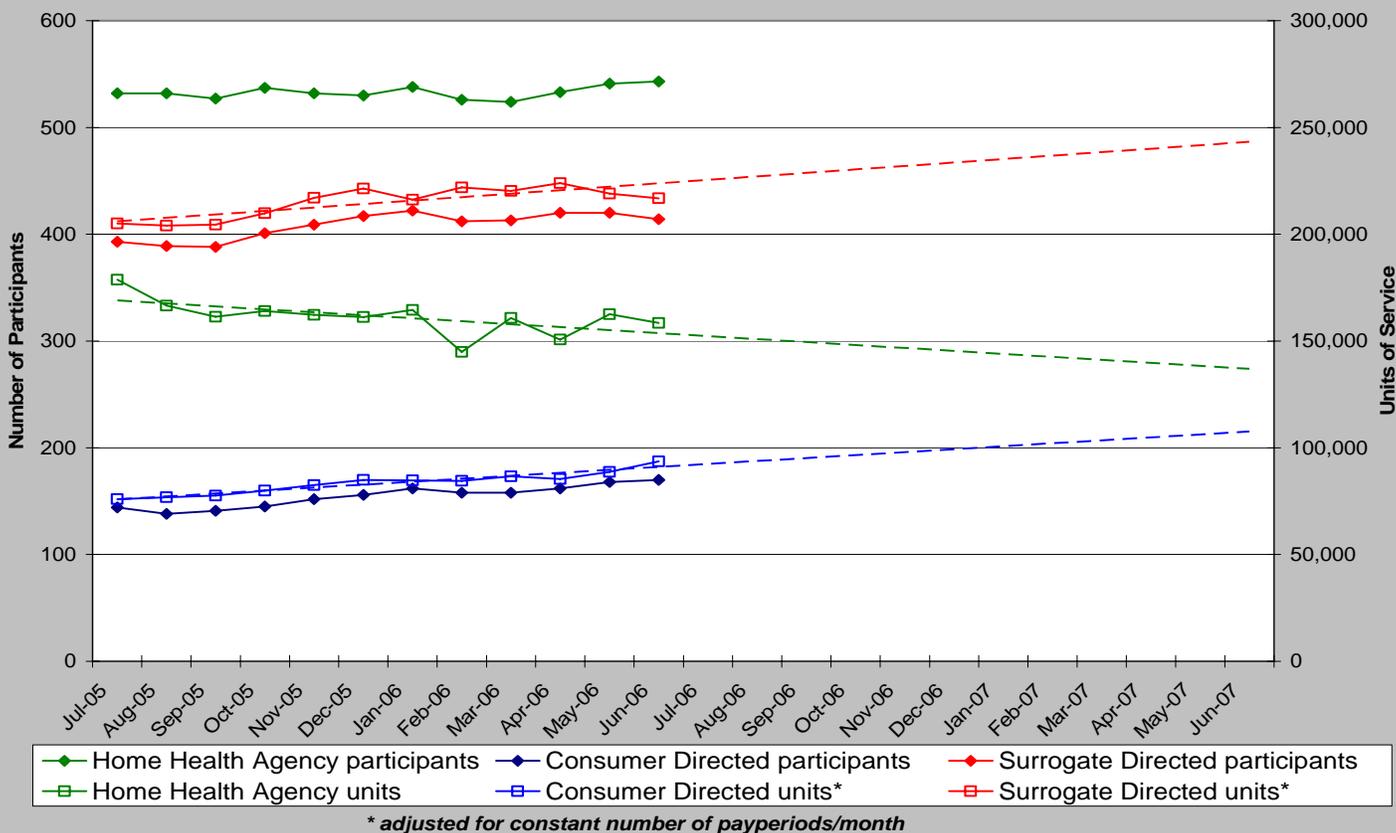


Personal care services are the core service in Vermont’s HCBS, representing nearly 80% of HCBS expenditures. This graph shows the types of personal care services that people have received over the last four years.

In sfy2002, consumer and surrogate directed service hours were roughly equal to home health agency service hours; each represented about 50% of the total hours. In the next four years, the number of consumer and surrogate directed service hours grew nearly 100%, while home health agency hours grew only 16%. By SFY2006, consumer and surrogate directed services represented about 65% of the total hours, while home health agency services represented about 35%.

If these trends continue for the next several years, consumer and surrogate directed services will come to represent 80% of all personal care service hours.

Choices for Care: Personal Care Participants and Service Units by Type, sfy2006



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

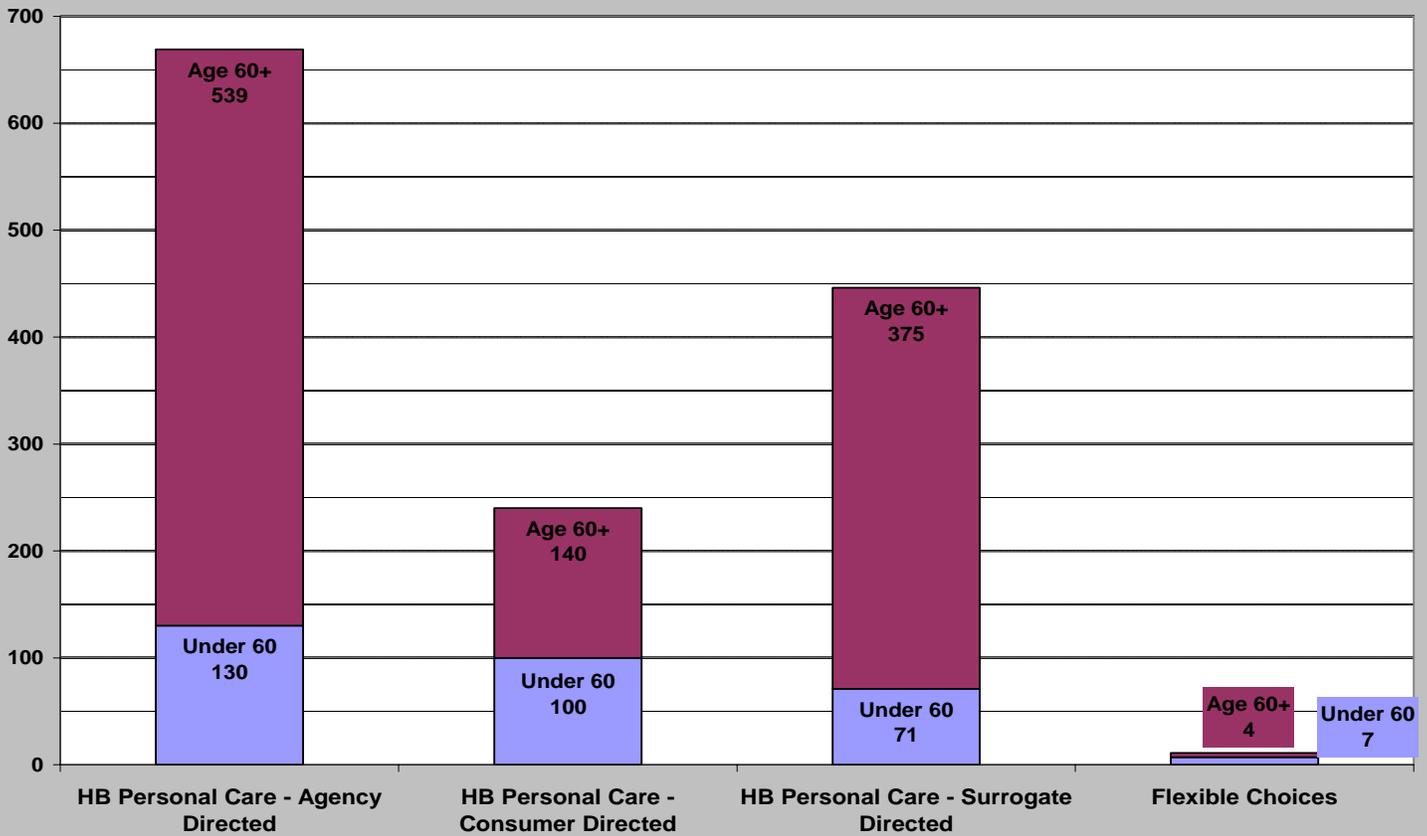
This graph shows trends in paid Medicaid claims (by dates of service) within sfy2006 for the three different Choices for Care personal care service options: home health agency, consumer-directed, and surrogate-directed.

Consistent with the trends established prior to Choices for Care, the fastest growth in service delivery in sfy2006 was found in surrogate-directed personal care services, followed by consumer-directed personal care services. It appears that the average number of hours provided to people through home health agency services may have decreased slightly in sfy2006. People who used consumer or surrogate directed services received more hours of service than those people who used home health agency services, contributing to the different trends.

These recent payment trends suggest that consumer and surrogate directed services will continue to increase, while home health agency services may actually decrease.

Again, consumer-directed and surrogate-directed personal care services represent about 65% of the personal care services that were provided in sfy2006. These services cost about \$12 million less than they would have cost if provided through an agency at higher reimbursement rates.

**Choices for Care Personal Care Services: Age of Active Participants by Type of Service
as of March, 2007**



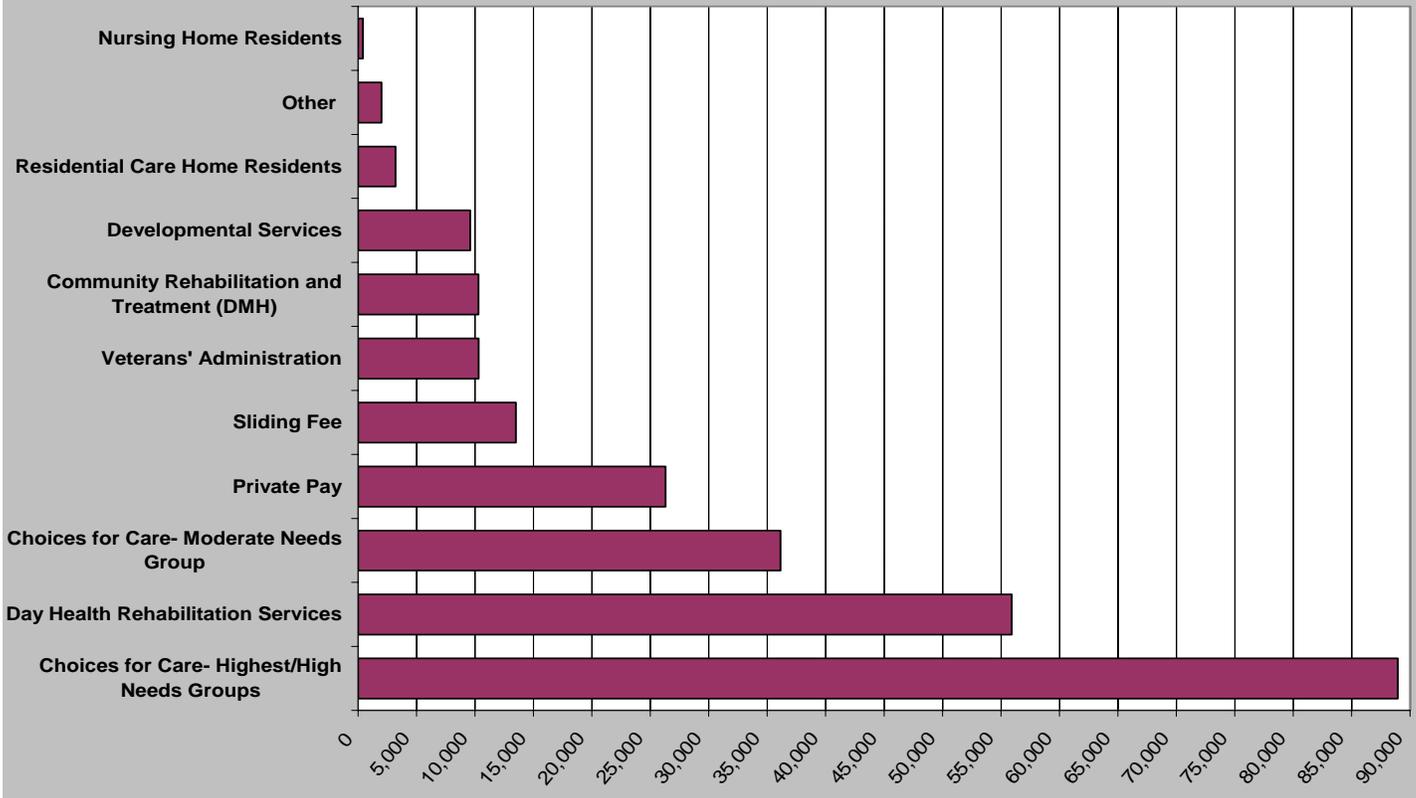
Data source: DAIL/DDAS SAMS database.

This illustrates the ages of people who chose the different personal care service options, including Flexible Choices.

While it is often assumed that a much higher percentage of older people will choose agency services, the percentage of people in each age group who use agency services is actually fairly similar: 51% of people age 60 and over, and 42% of people under age 60.

There are more substantial differences between the two age groups in the other service options. 35% of older people use surrogate directed services, compared to only 23% of younger people. Conversely, 32% of younger people use consumer directed services, compared to only 13% of older people. The number of people using Flexible Choices remains very small, although it is expected to grow in the coming months.

**Vermont Adult Day Service Hours by Type of Reimbursement, sfy2007
July 2006-December 2006**



Data source: Adult Day provider reports

This graph shows the variety of reimbursement sources that supported adult day services in Vermont during the period July 2006 – December 2006. The data comes from monthly service data submitted to DAIL by Vermont’s adult day providers.

Medicaid is currently the primary source of reimbursement for adult day services. Vermont Medicaid paid for nearly 80% of all services in the first half of SFY2007, with Choices for Care paying for about 71% of all services:

<u>Percent of Units</u>	<u>Type of Service</u>
35%	Choices for Care Highest and High Needs Groups
22%	Day Health Rehabilitation Services
14%	Choices for Care Moderate Needs Group
4%	Community Rehabilitation and Treatment (Mental Health)
4%	Developmental Services