



Choices for Care

Quarterly Data Report

October 2007

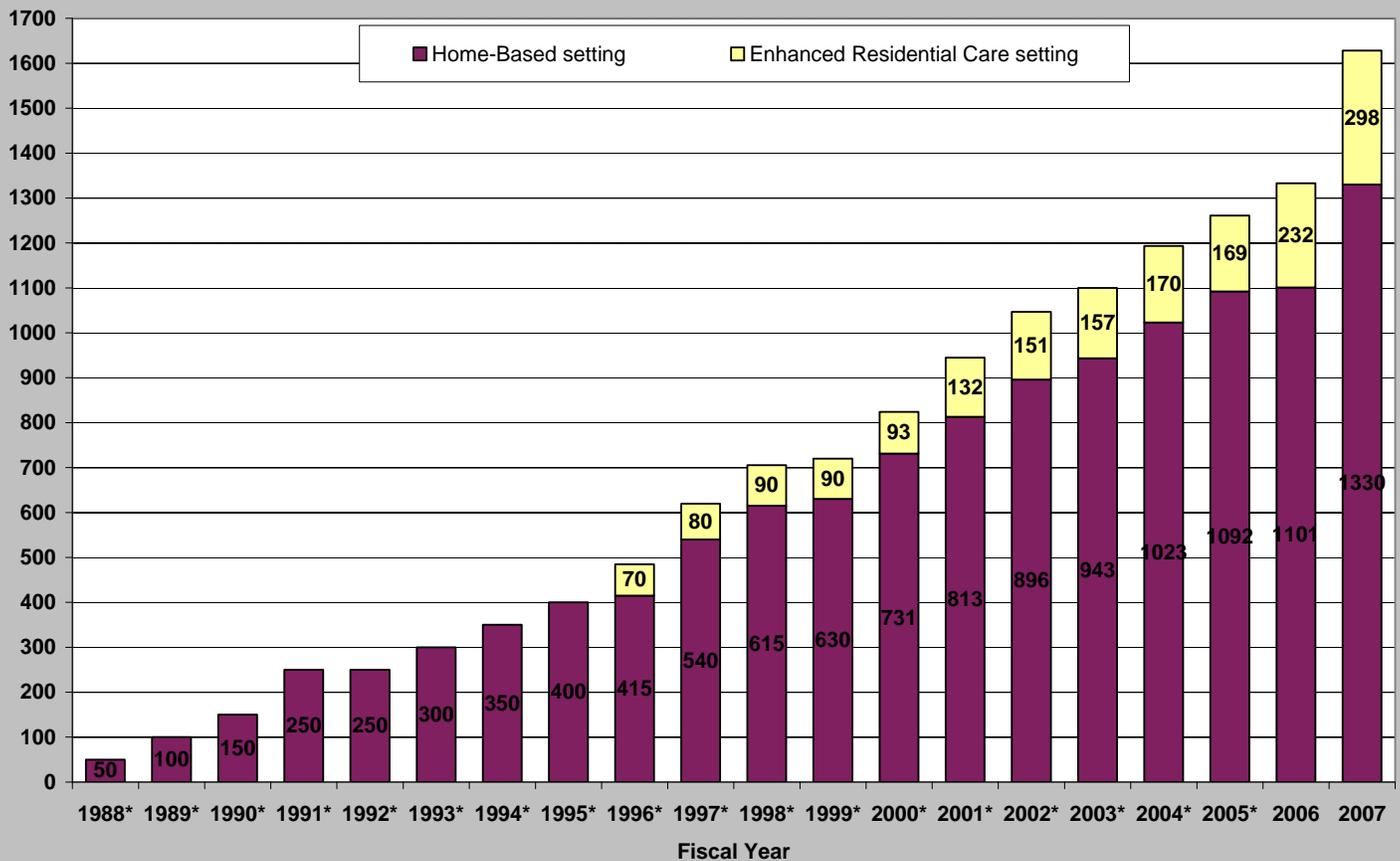
This report documents the status and progress of Choices for Care, Vermont's Medicaid long term care service system. This report is intended to provide useful information regarding enrollment, service, and expenditure trends in Choices for Care. A brief explanation accompanies each graph, chart or table.

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 resident days of service submitted by Vermont nursing homes to the Division of Rate Setting.

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
bard.hill@dail.state.vt.us
<http://dail.vermont.gov>

**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

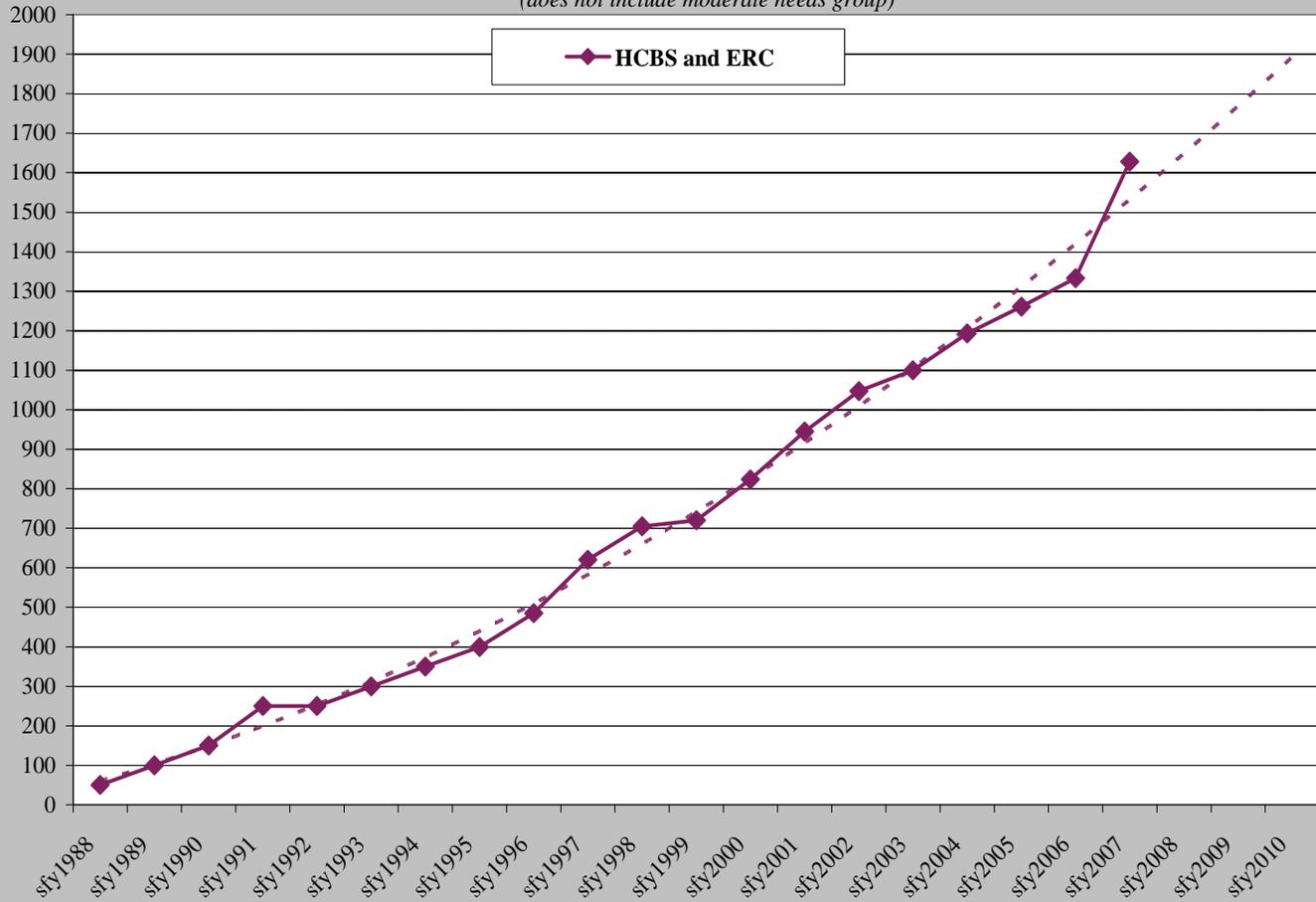
This graph illustrates the growth in home and community based services in Vermont for people over age 60 and people with physical disabilities since sfy1988.

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 those years all eligible Vermonters were entitled to receive nursing home care under Medicaid, but were not entitled to receive alternative home and community-based long term care services. Some people who applied for home and community based services were placed on waiting lists until funding became 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

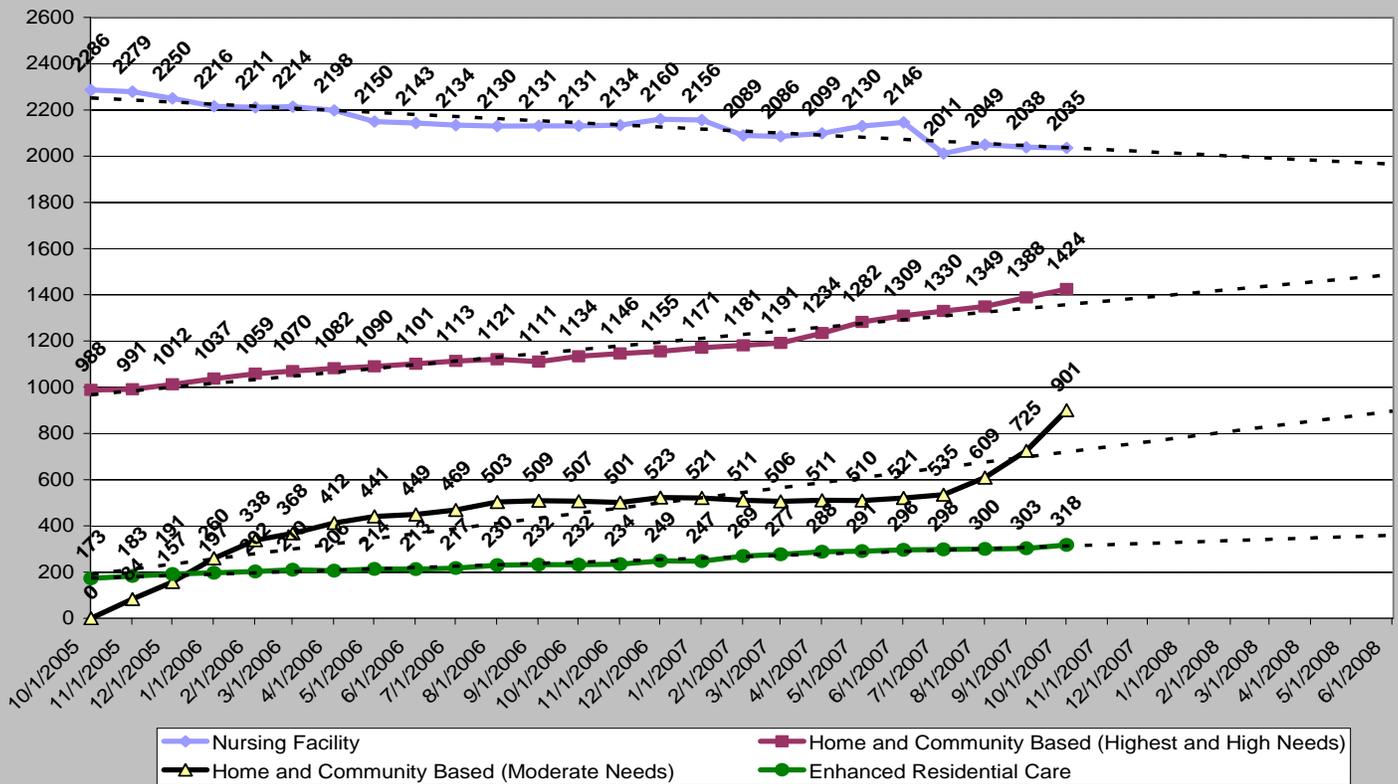
(does not include moderate needs group)



Data source: DAIL/DDAS databases

This graph combines HCBS and ERC enrollment data, and projects the historical enrollment trend through sfy2010. Note the steep growth following the implementation of Choices for Care in sfy2006. Based on past trends, one can expect continued growth in enrollment in these settings.

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



Data source: DAIL/DDAS SAMS database.

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

Nursing homes: the number of people enrolled in the nursing home setting decreased by about 250 between October 2005 and October 2007. During this same period, overall nursing home capacity also decreased -- by 140 beds:

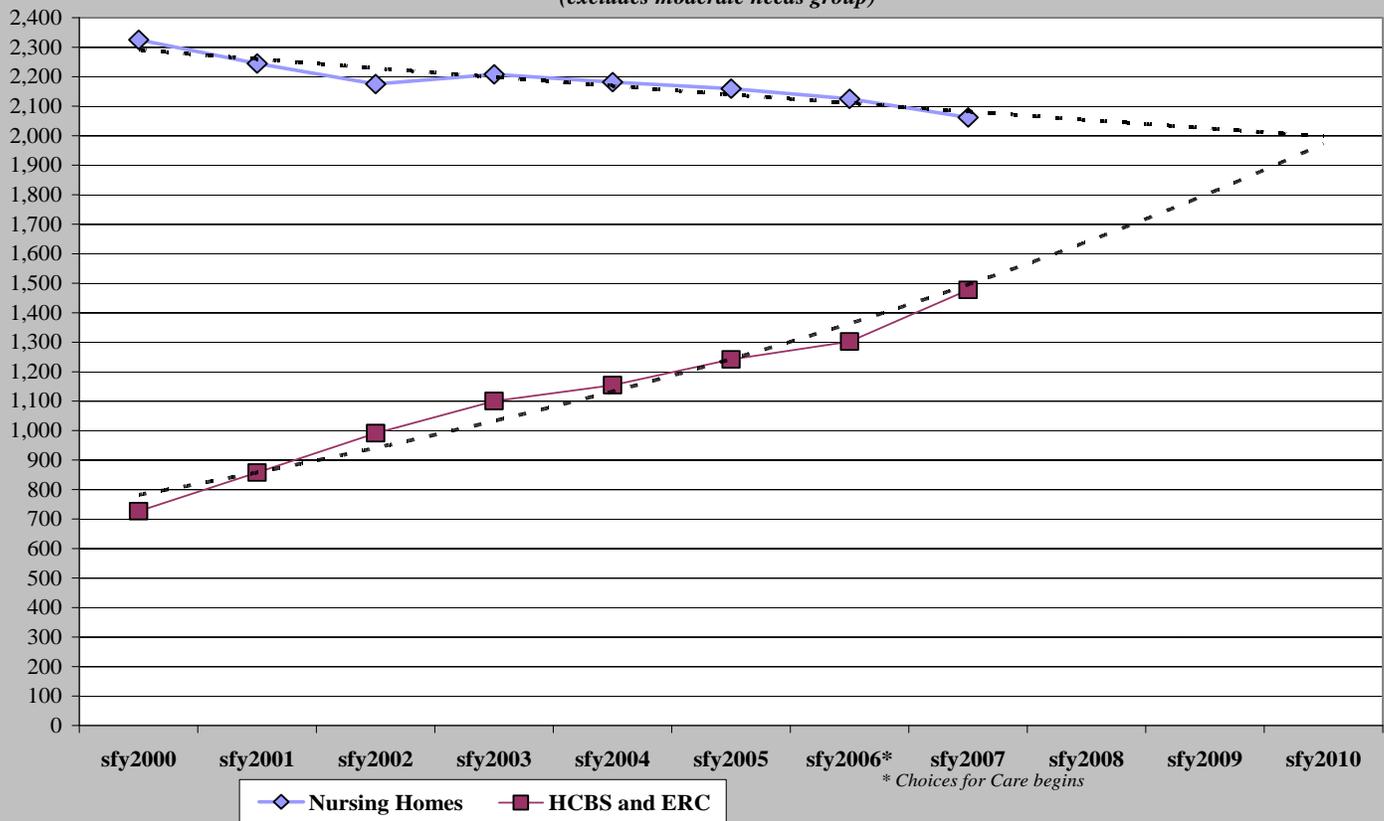
Oct-05	Orleans	Newport Health Care Center	-10
Jan-06	Windsor	Mt. Ascutney Health Center	-8
Sep-06	Orange	Menig Extended Care	+10
Oct-06	Chittenden	Burlington Health & Rehab.	-42
Feb-07	Lamoille	Morrisville Genesis	-90

Home and Community Based Services (Highest/High Needs Groups): the number of people enrolled increased by more than 400 between October 2005 and October 2007.

Enhanced Residential Care: the number of people enrolled increased by nearly 150 between October 2005 and October 2007. Some people transitioned to ERC settings from Traumatic Brain Injury Waiver services and from nursing homes, contributing to this increase.

HCBS Moderate Needs Group: this 'expansion' group was created in October 2005, and by October 2007 had grown to more than 900 people. Large increases in Moderate Needs Group enrollment in sfy2008 were supported by funds that were moved from the state-funded homemaker program.

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

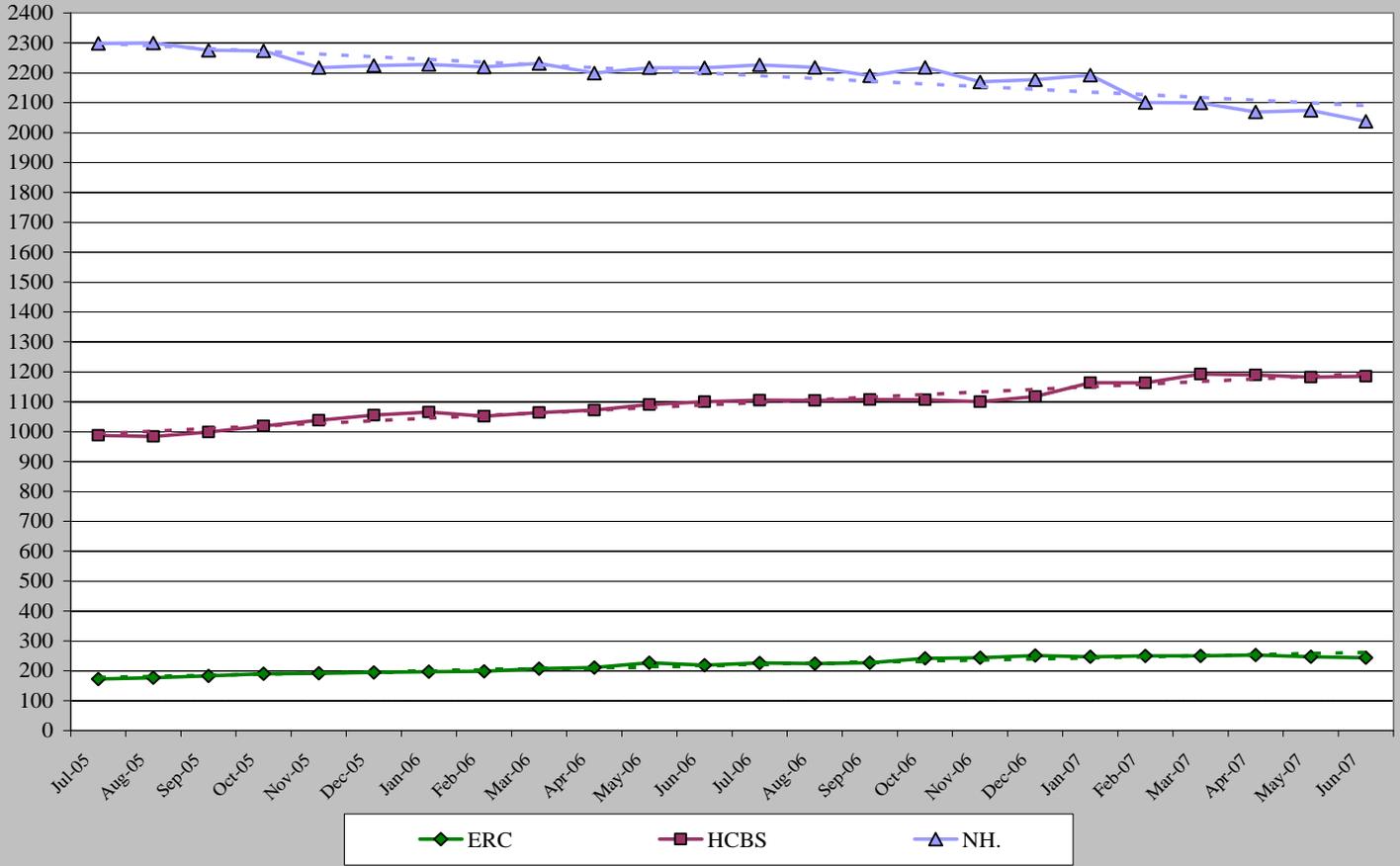


Data sources: DAIL/DDAS enrollment data; DAIL Monthly Monitoring Report; Division of Rate Setting

This graph compares trends in service settings since sfy2000, using a second data source for nursing home services (“resident days of service” reports submitted by nursing homes to the Division of Rate Setting).

The trends suggest that the number of people served in nursing homes will continue to gradually 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: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



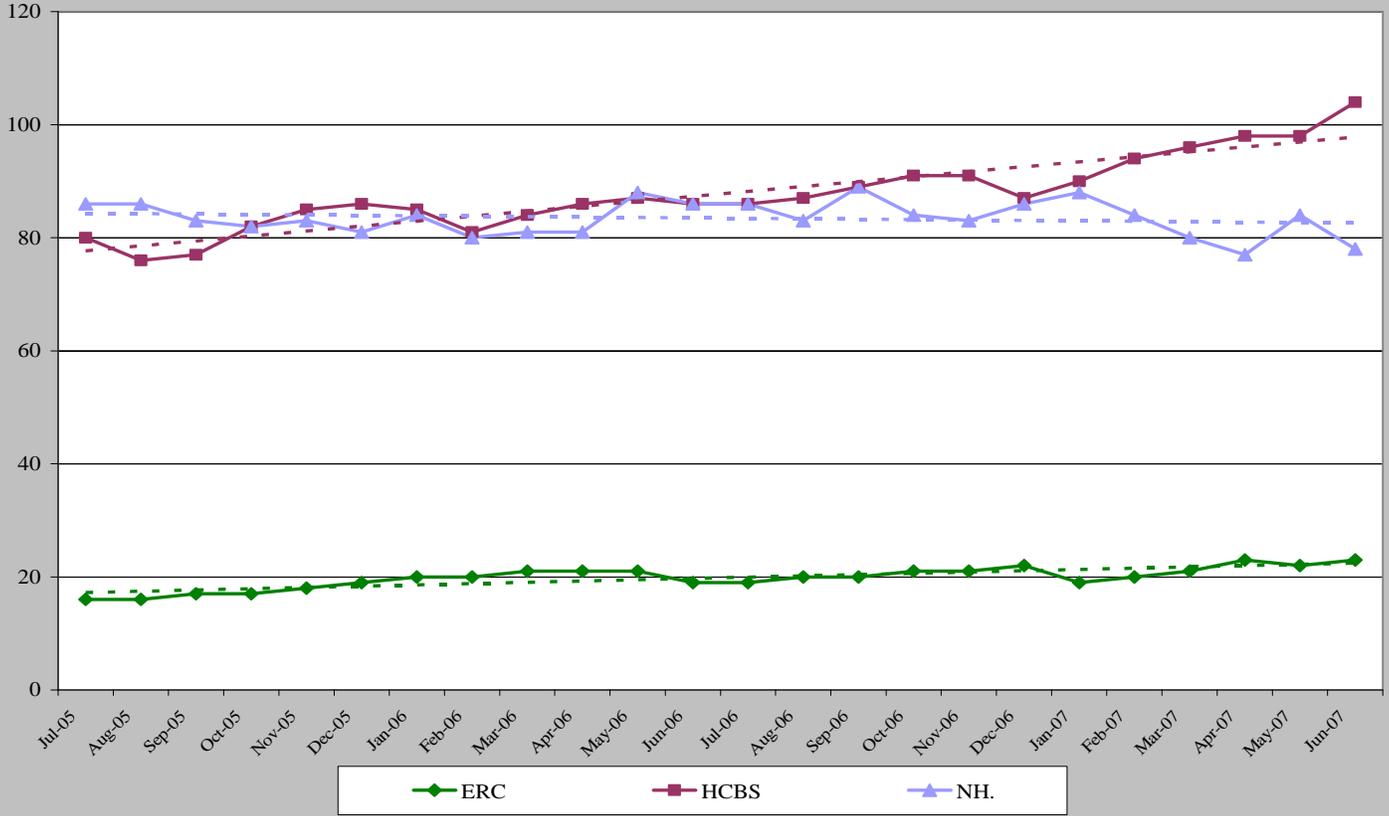
Data source: EDS paid claims, by date of service

This graph shows statewide trends in the numbers of people served by setting, using Medicaid paid claims data. Medicaid paid claims data represents services that are actually provided- generally the “gold standard” for Medicaid service utilization data.

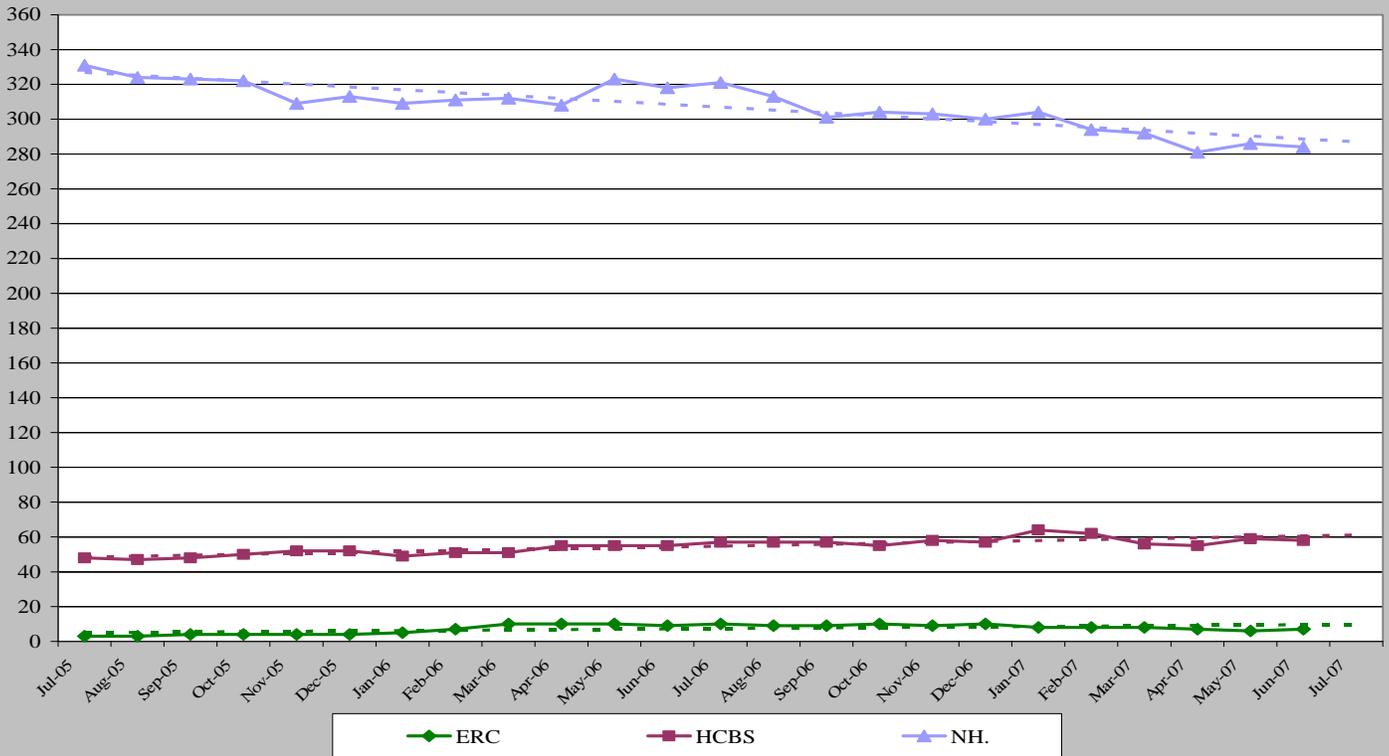
While this graph represents a shorter time period, it reveals the same statewide patterns that are seen in other data sources: decreasing use of nursing home services, accompanied by increasing use of Home and Community-based services and Enhanced Residential Care.

The graphs on the following pages show this data for each individual county. Because of the absence of nursing homes in Essex and Grand Isle Counties, graphs were not prepared for these counties.

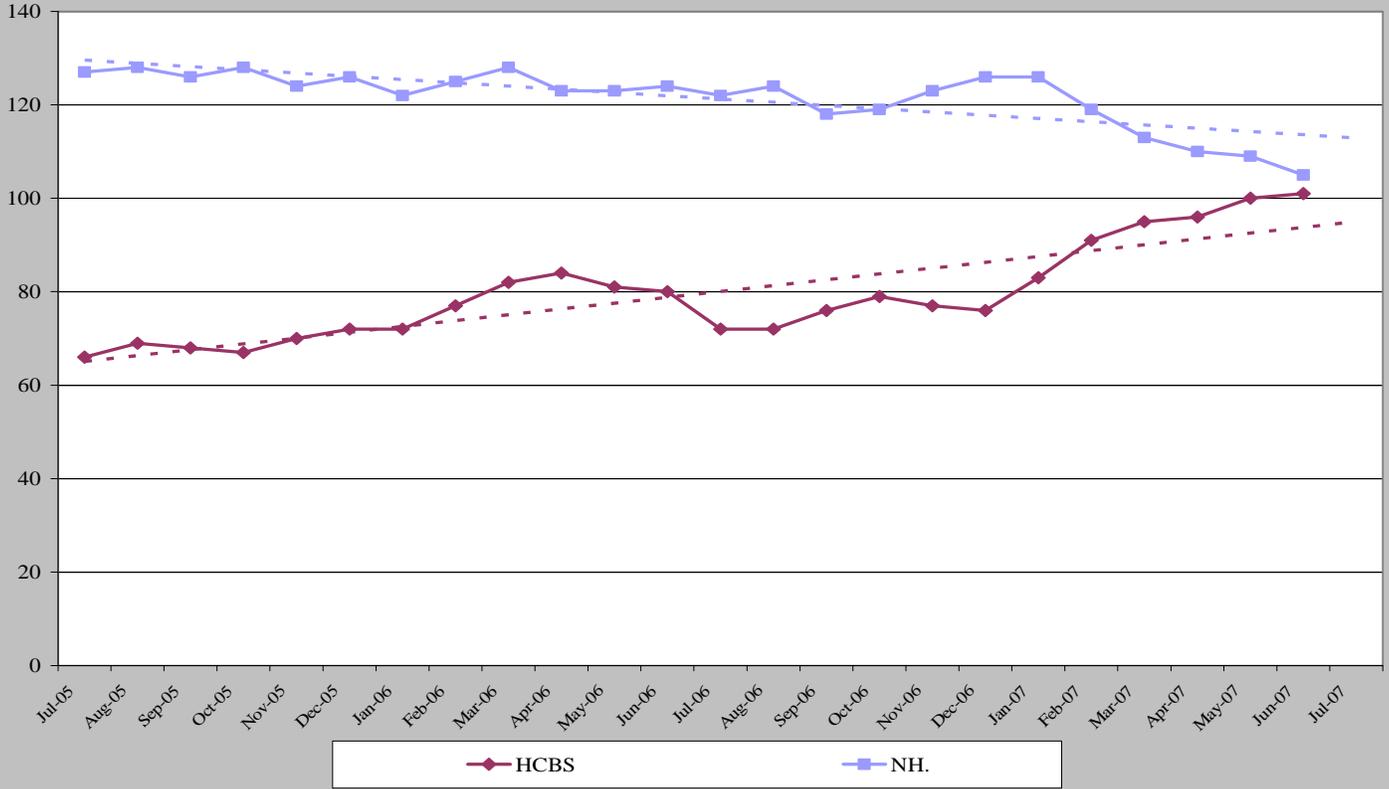
Addison County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



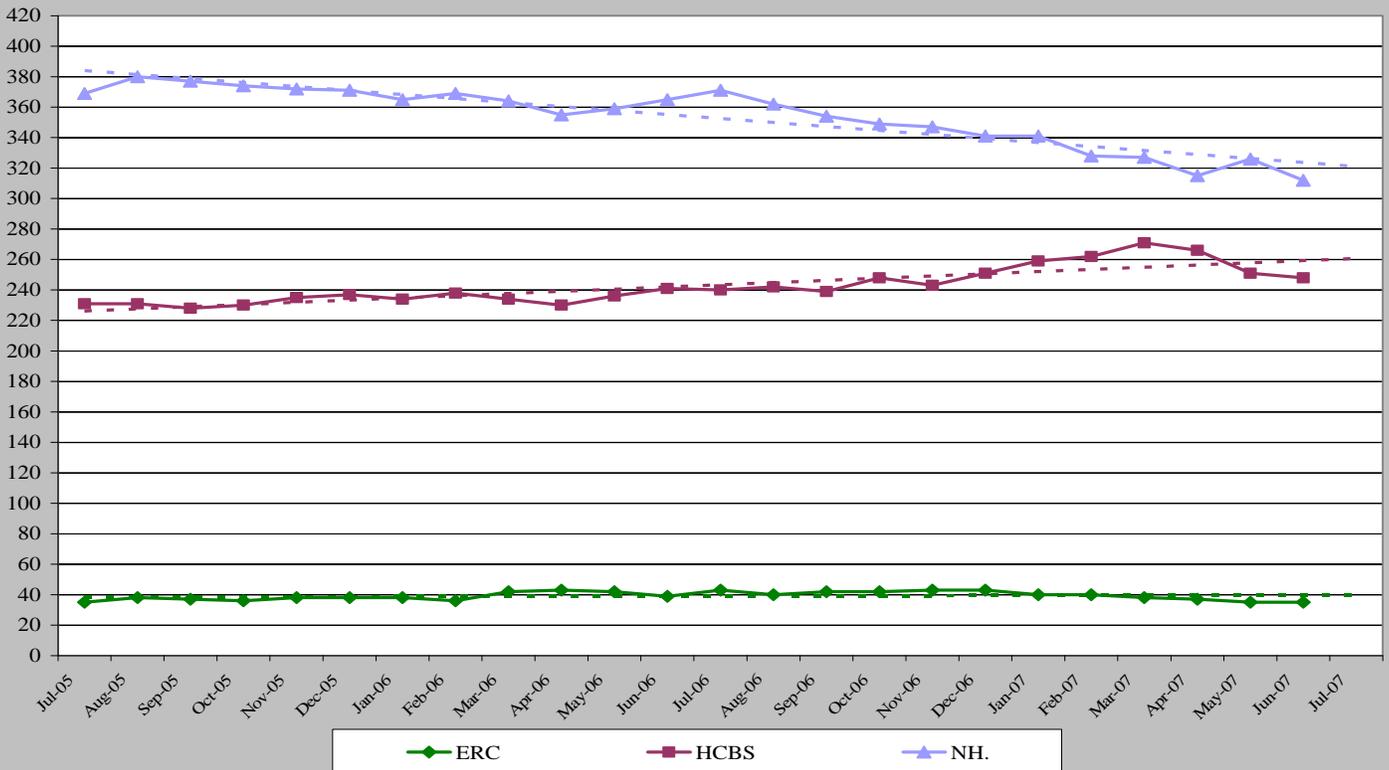
Bennington County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



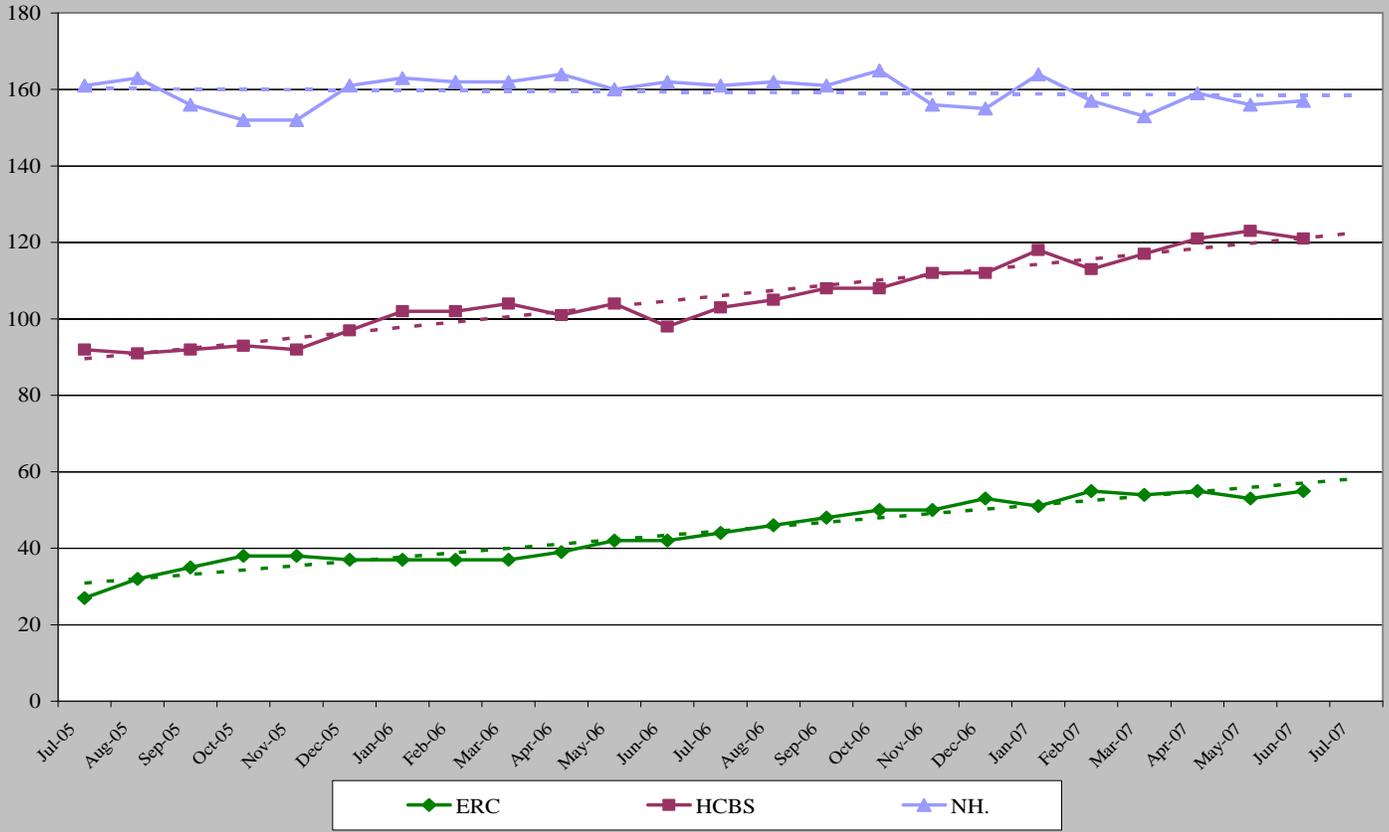
Caledonia County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



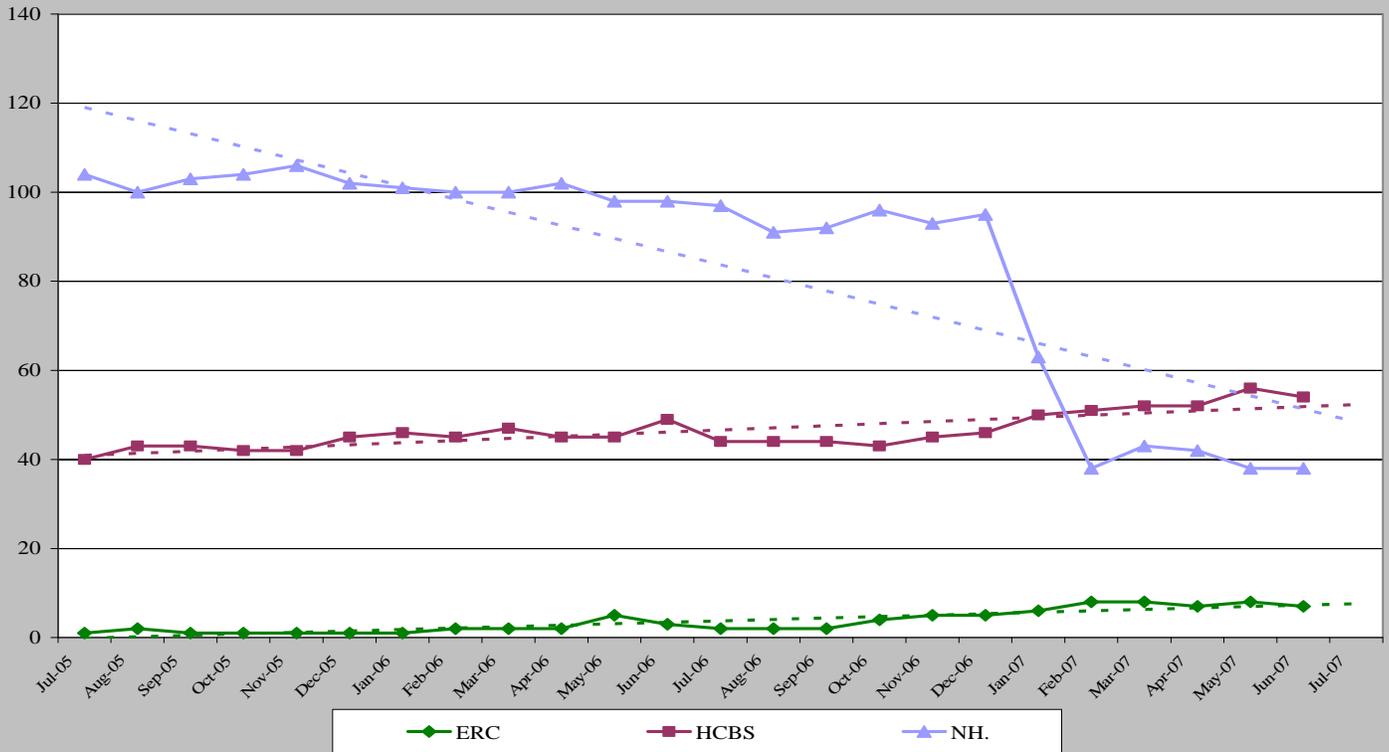
Chittenden County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



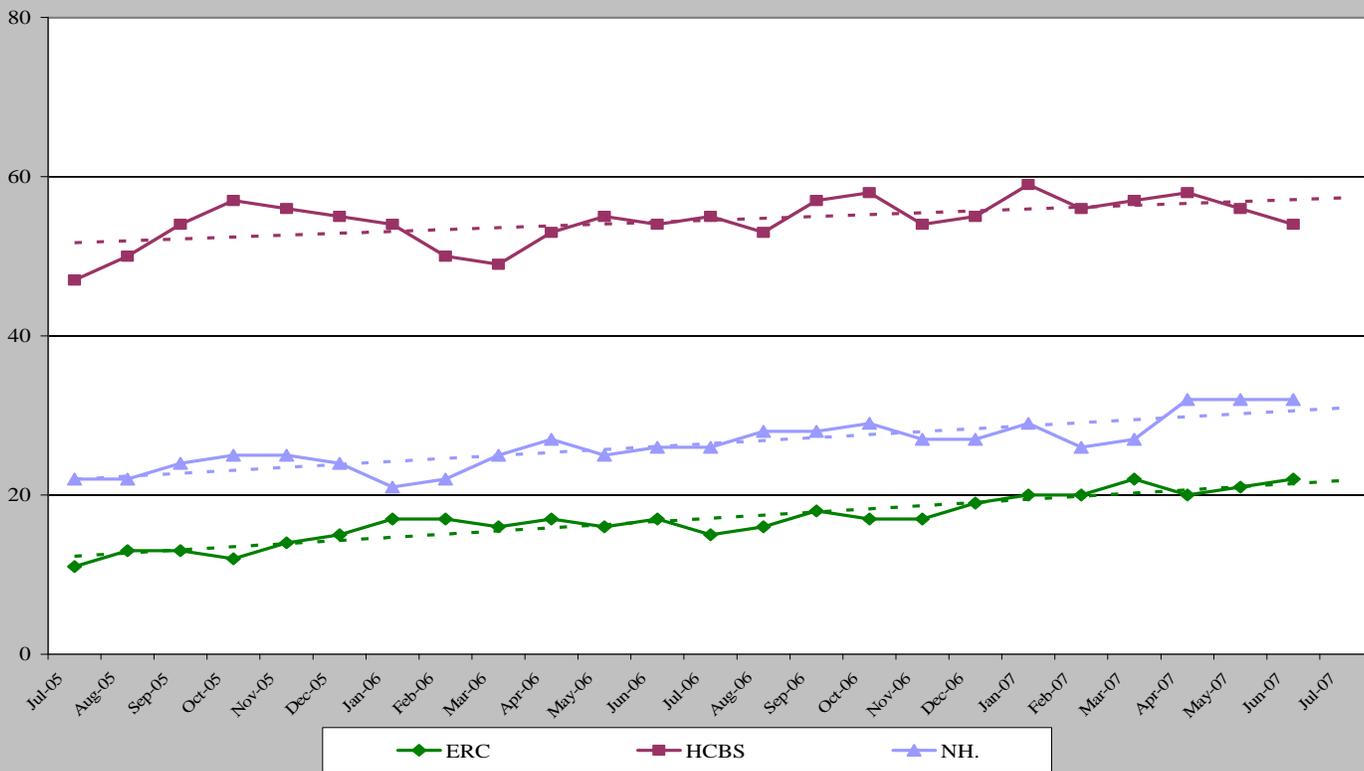
Franklin County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



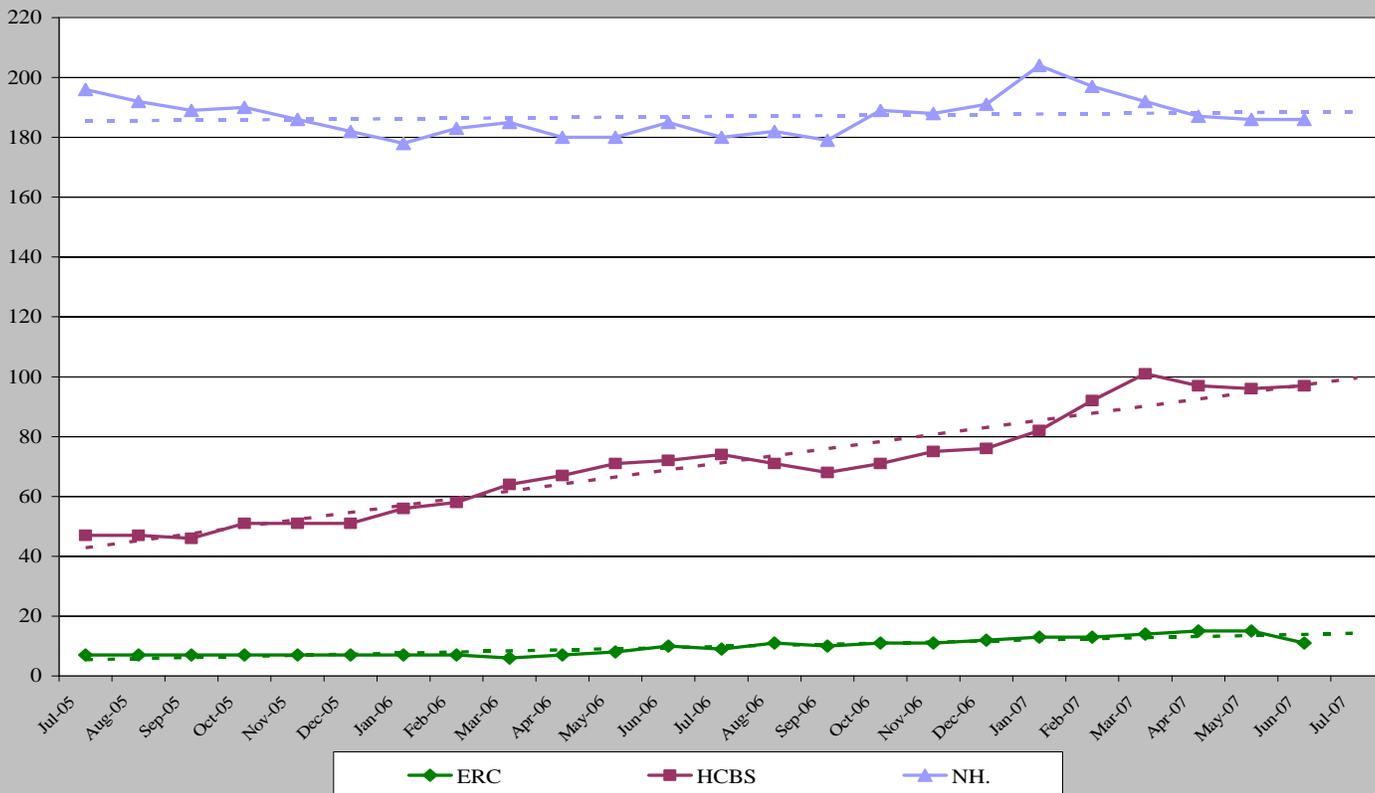
Lamoille County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



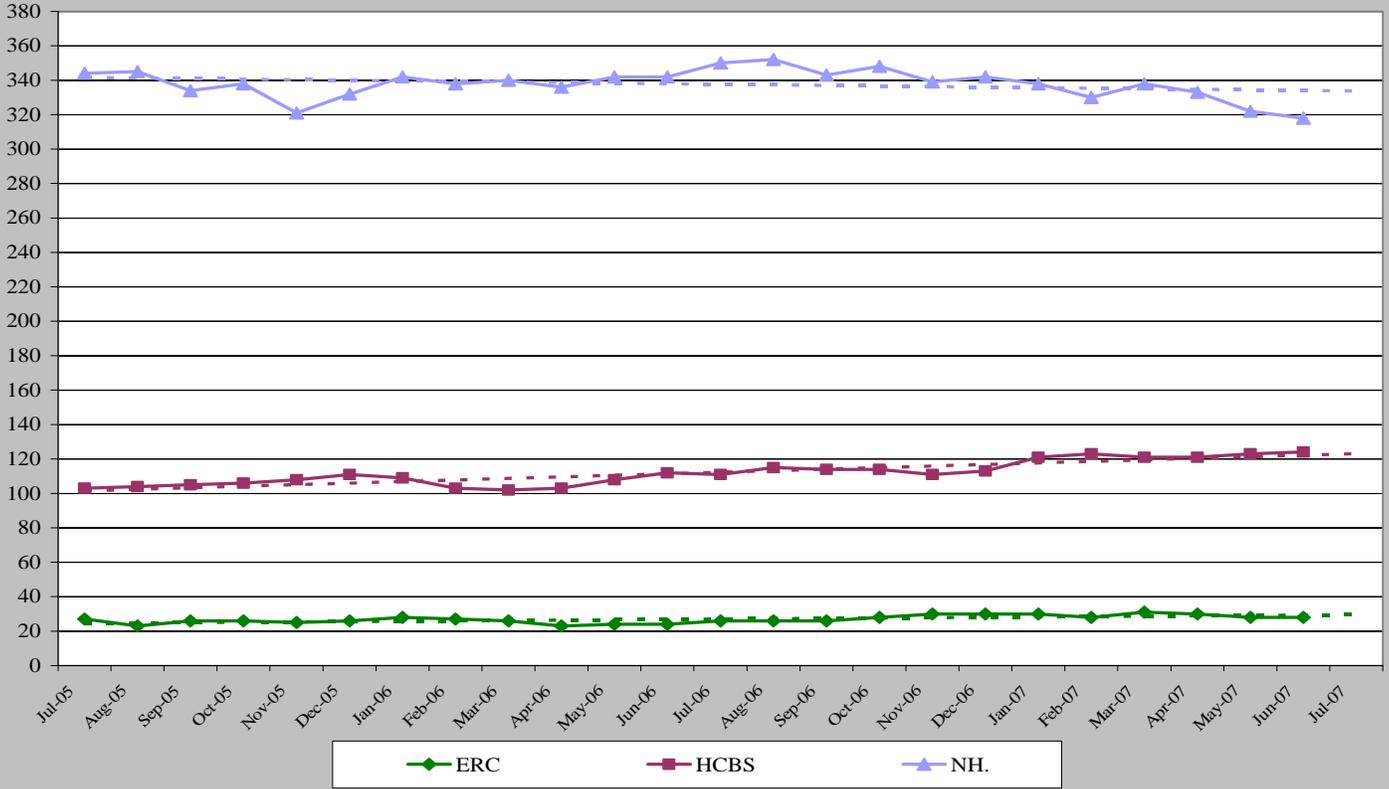
Orange County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



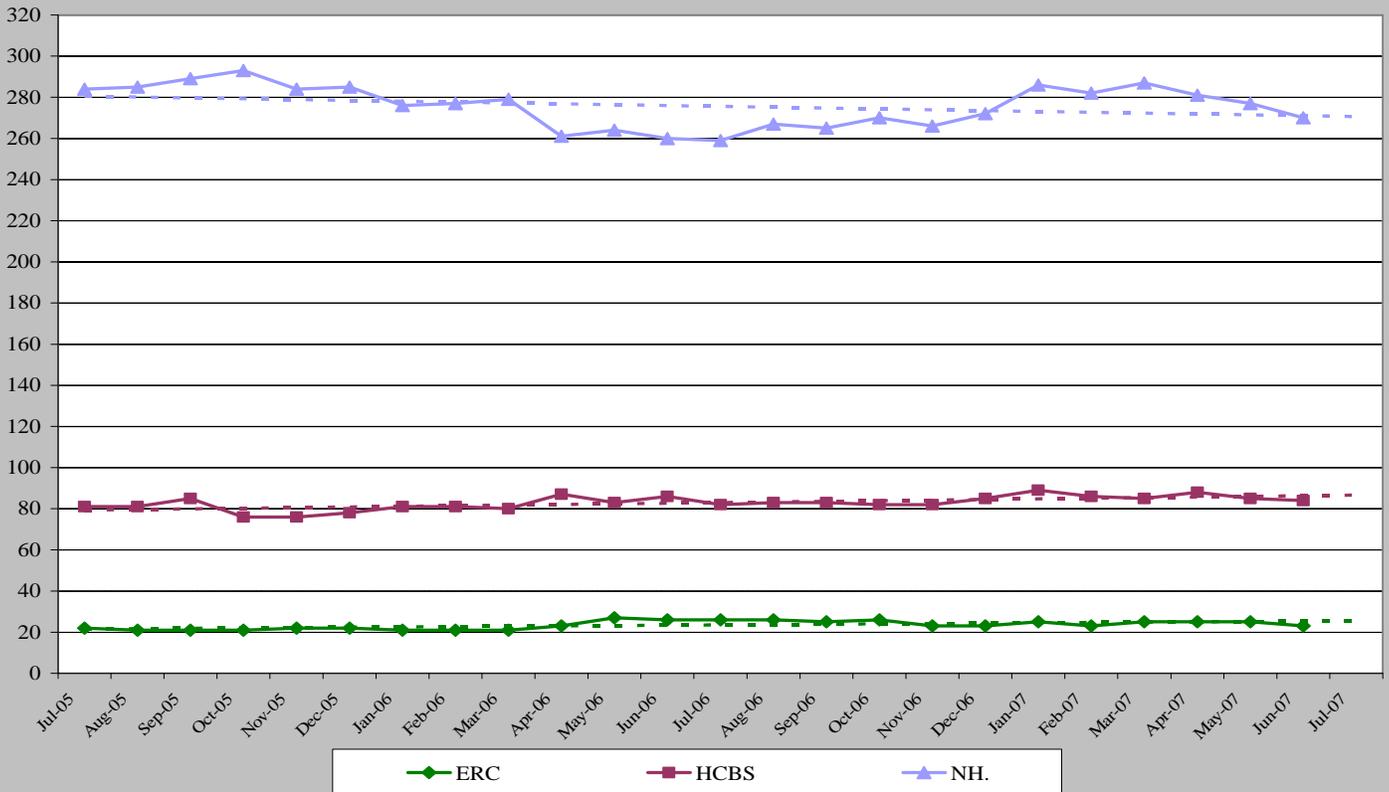
Orleans County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



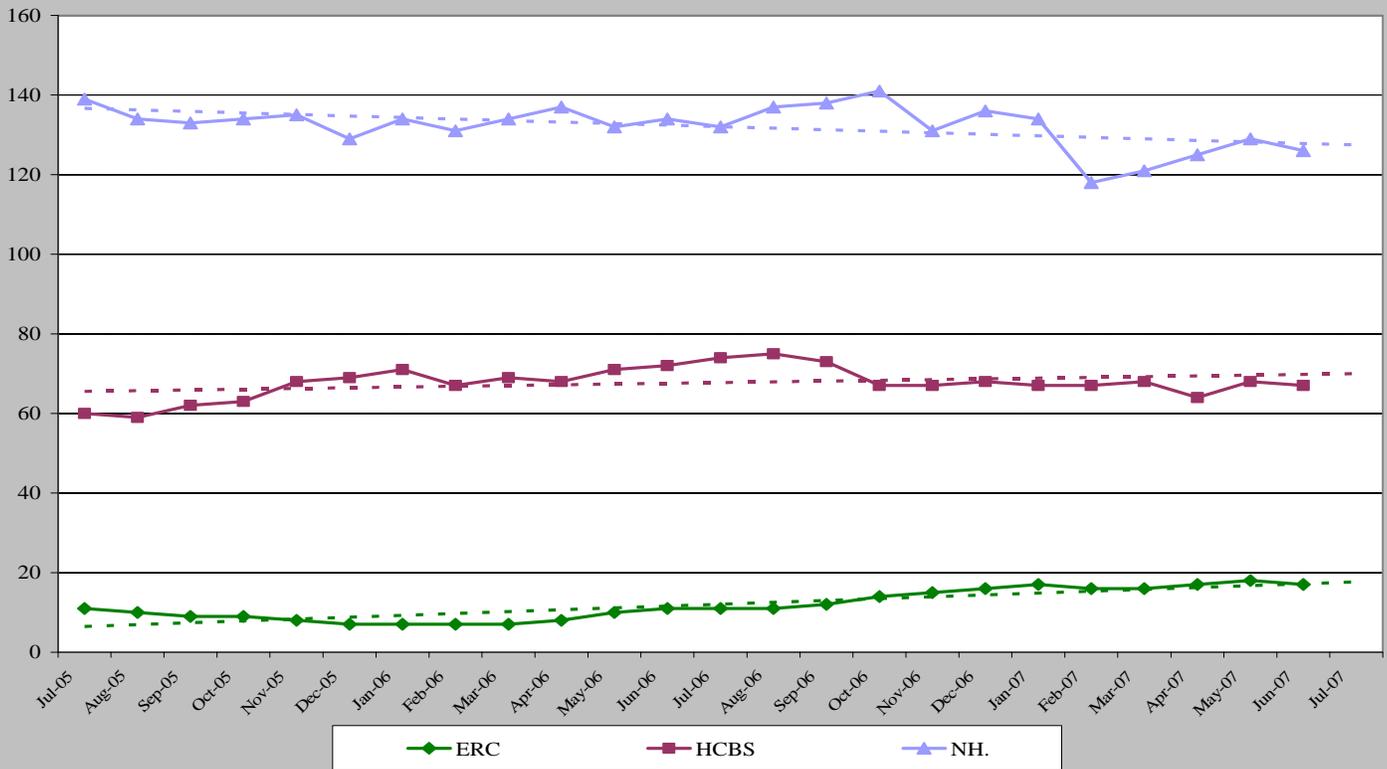
Rutland County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



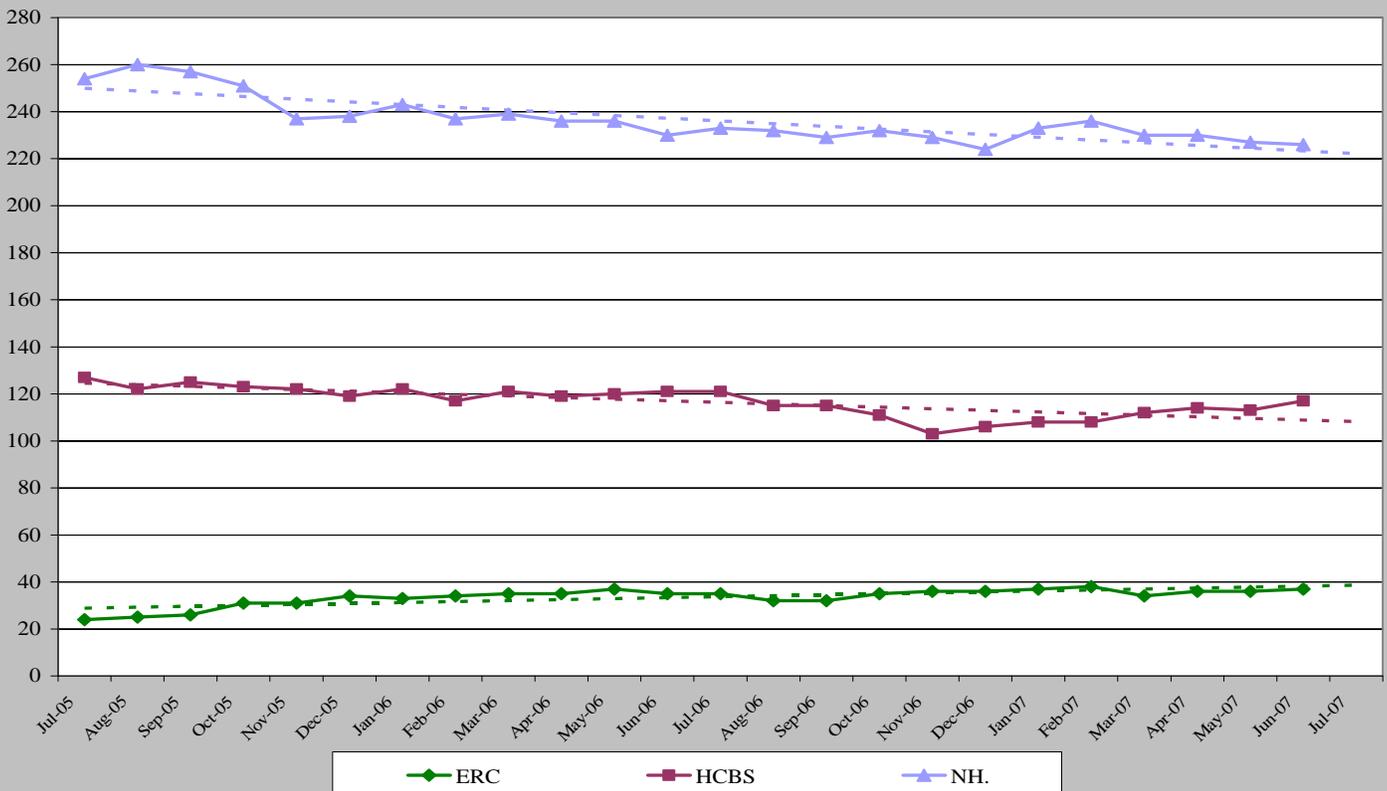
Washington County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



Windham County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers

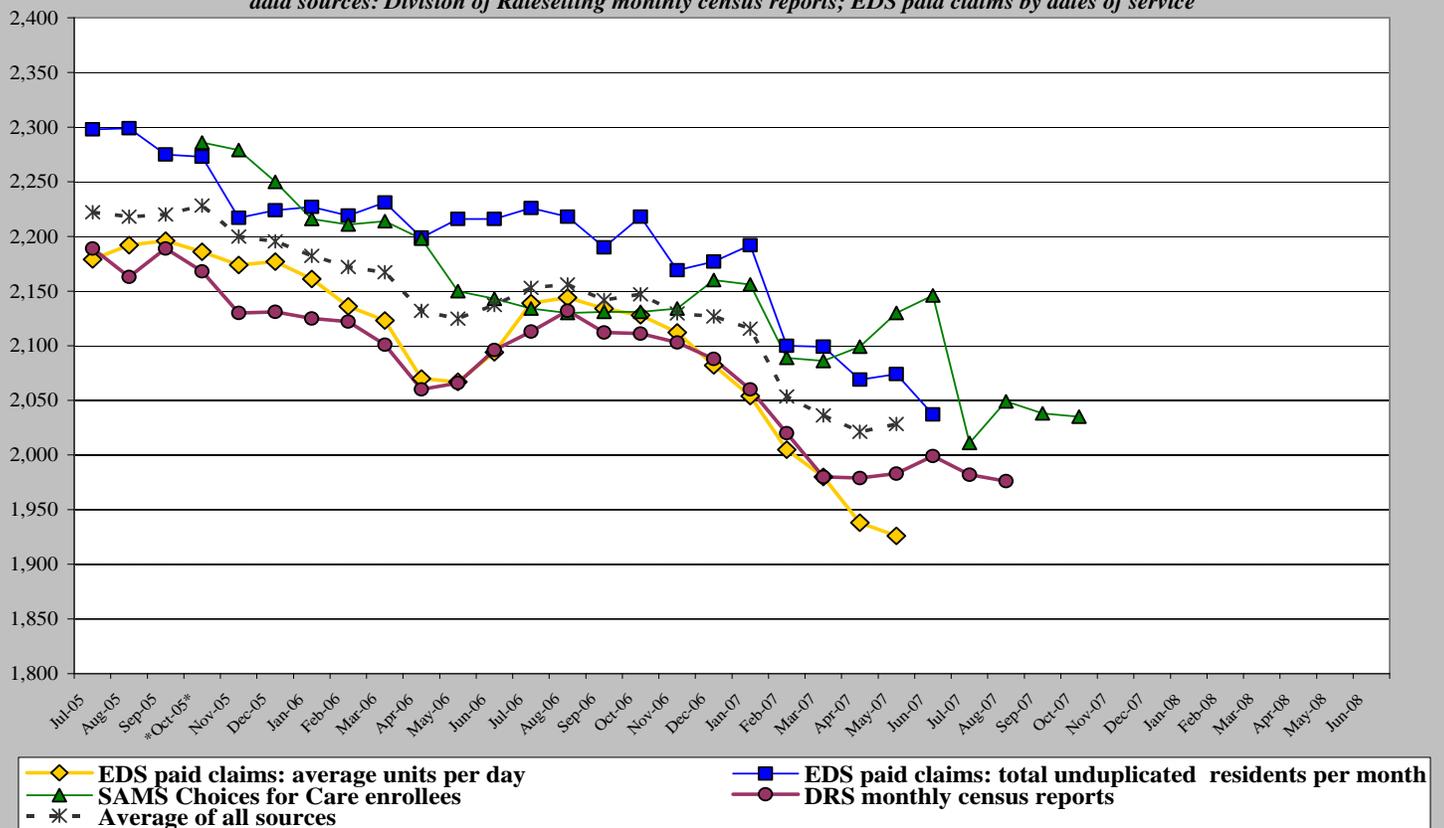


Windsor County: Choices for Care Number of People Served by Setting by Month, sfy2006-sfy2007
data source: EDS paid claims by dates of service, total unduplicated numbers



Vermont Long Term Care Medicaid: Average Number of Nursing Home Residents by Month, sfy06-sfy08

data sources: Division of Ratesetting monthly census reports; EDS paid claims by dates of service



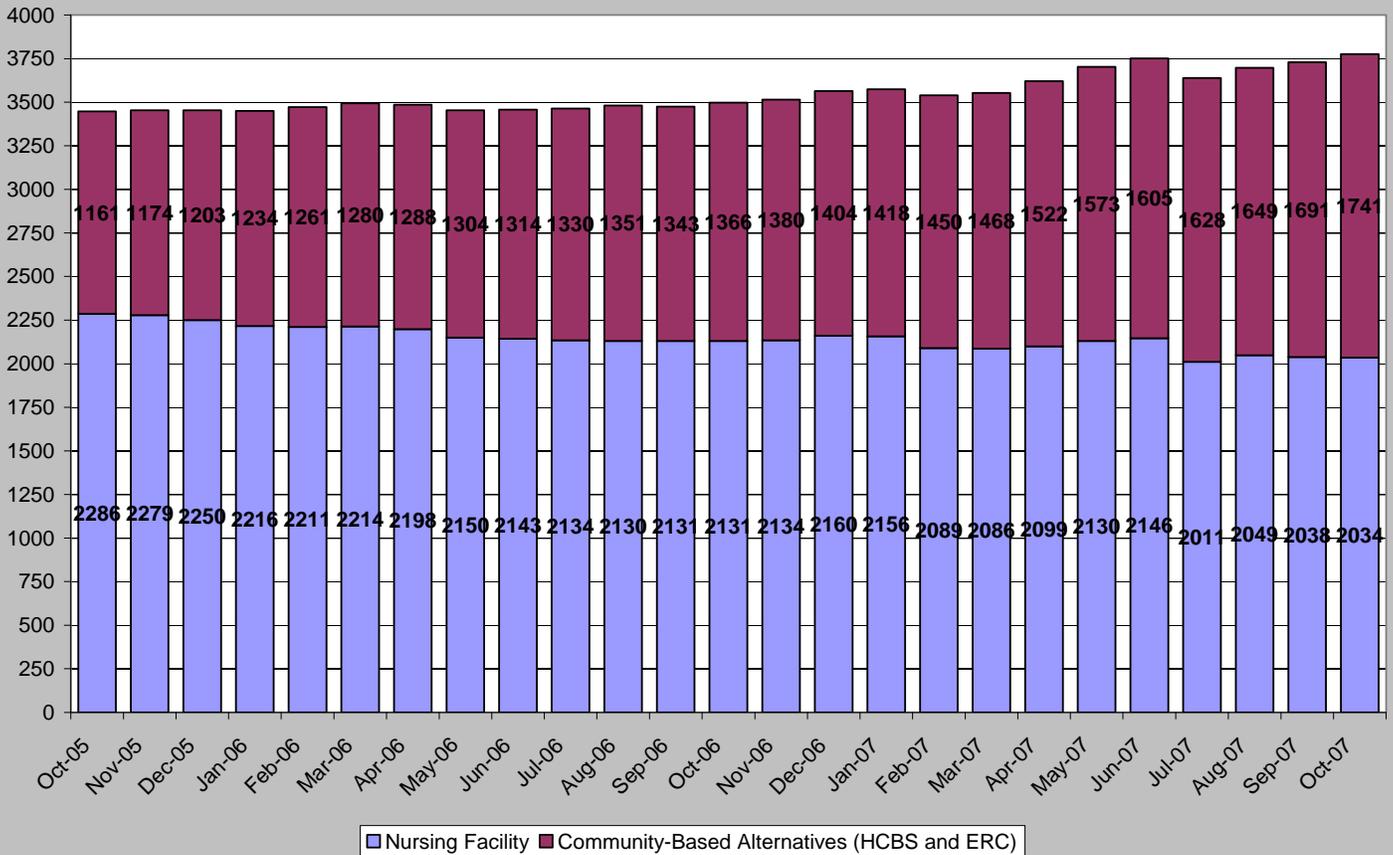
Data sources: DAIL/DDAS SAMS database; EDS paid claims, by date of service; Division of Rate Setting.

This graph shows trends in the use of nursing homes under Medicaid using three different data sources. On average, DRS data is within about 1% of the EDS paid claims data. On average, SAMS data is within about 3% of the EDS paid claims data.

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 until 3-9 months after the date of service. Note that a small number of claims adjustments can occur more than a year after the dates of service.
2. SAMS enrollment: These enrollment data are maintained by DAIL, and are used to track applications and eligibility. These data are heavily reliant on timely information from providers regarding admissions and discharges.
3. Division of Rate Setting monthly census reports: These monthly “days of service” data are submitted by nursing homes to the Division of Rate Setting (DRS), and include all funding sources. Note that a small number of data adjustments can occur more than a year after the dates of service.

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. The EDS and DRS data clearly show the impact of the closing of nursing home beds in October 2006 and February 2007.

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



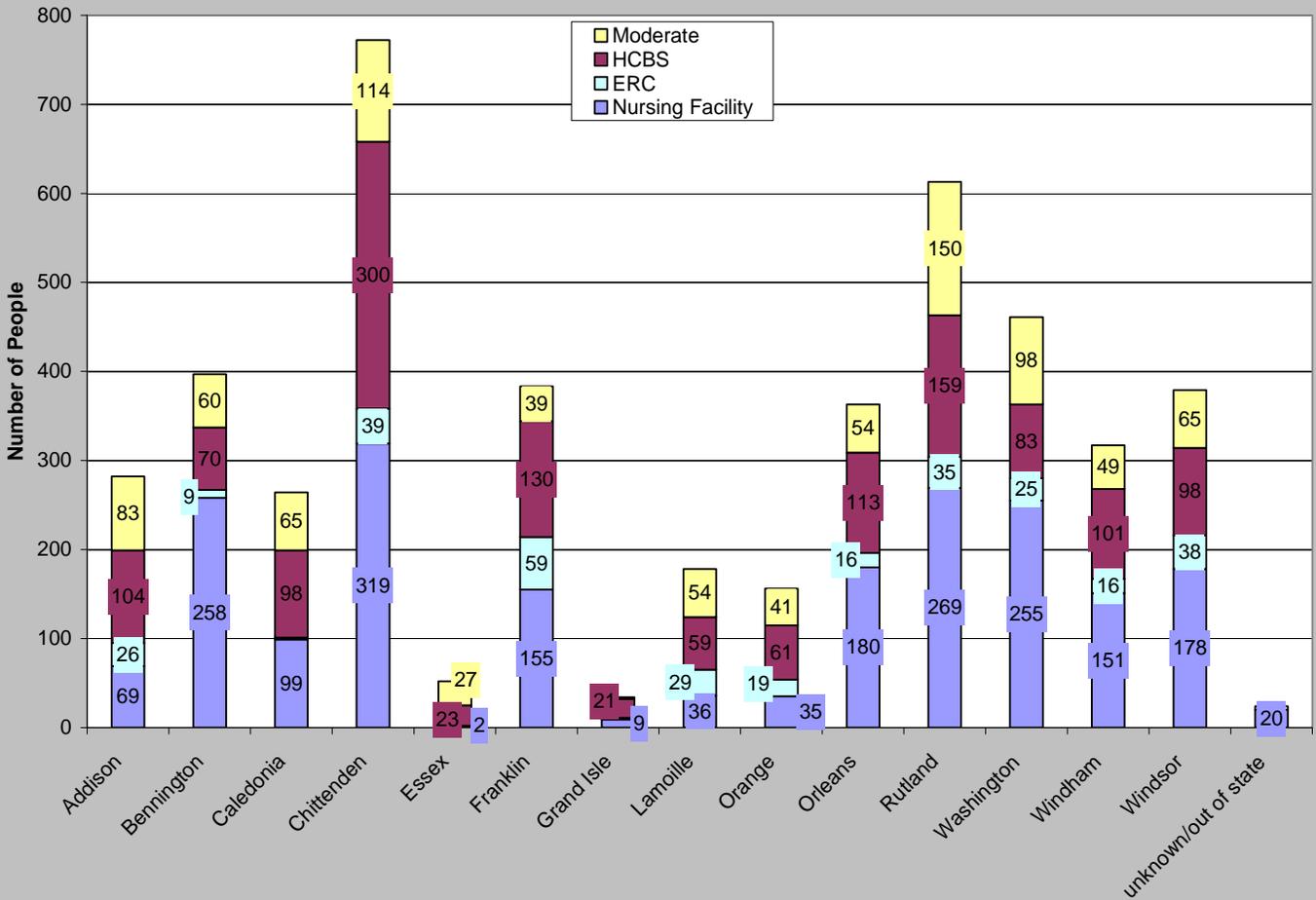
Data source: DAIL/DDAS SAMS database.

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

The total number of people enrolled in these two groups has grown modestly. In two years, the total number enrolled has increased by more than 300 people (about 10%). Prior to Choices for Care, the annual increase in the number of people enrolled in HCBS and ERC was about 100.

The experience of two years suggests that initial concerns about a ‘woodwork effect’-- in which large numbers of people would enroll in Medicaid long term care services, causing unsustainable increases in total costs-- remain unfounded.

**Choices for Care: Enrolled Participants by Setting by County
as of October 2007**



Data source: DAIL/DDAS SAMS database.

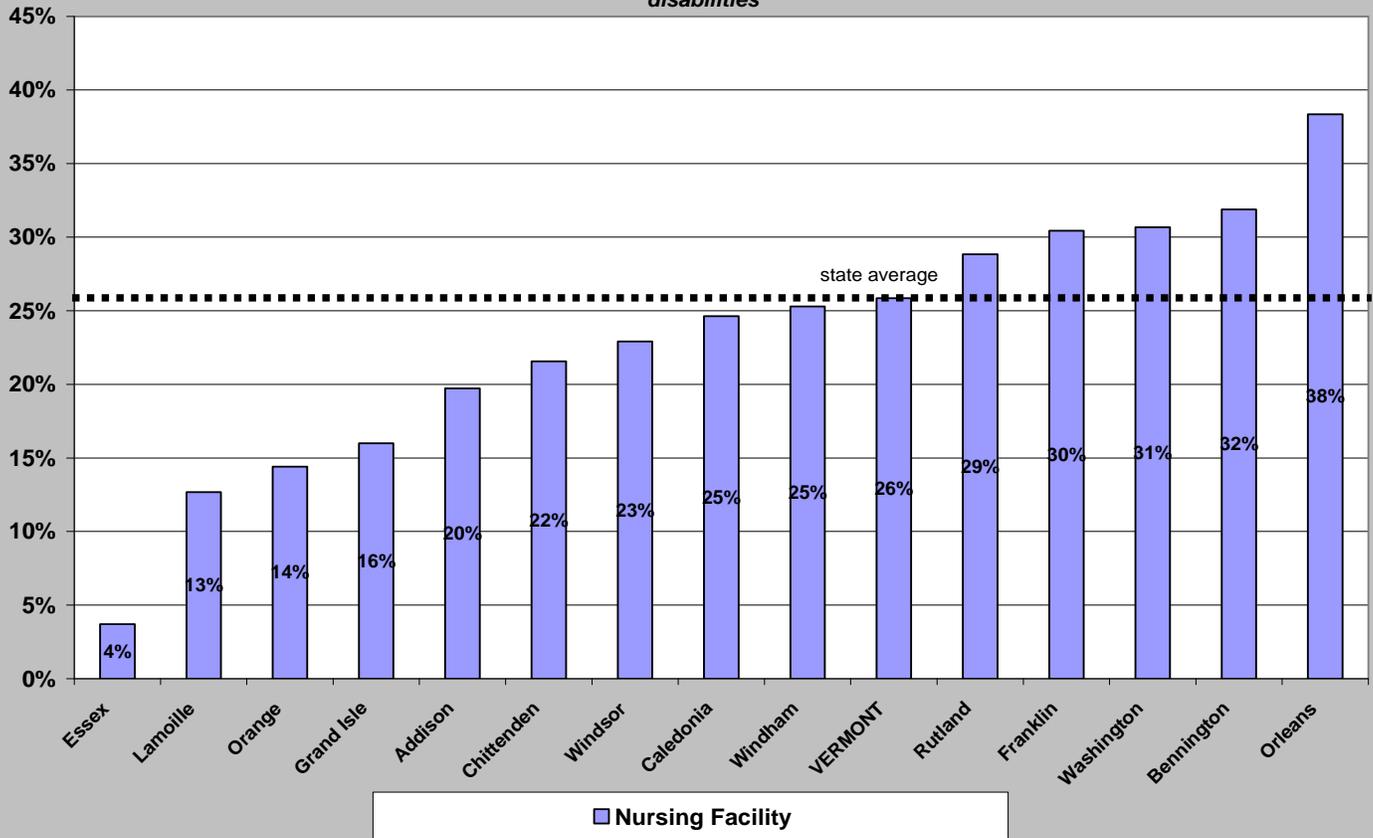
This graph shows the settings in which Choices for Care participants are served, by county. The graph can be used to compare the numbers of people served in each setting within each county, as well as the numbers of people served across all counties.

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, 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: Number of People Served as Percentage of Estimated Number of People with Disabilities (2+ ADLs) by County - October 2007

Aged 18+, all income groups, including NF, 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*.

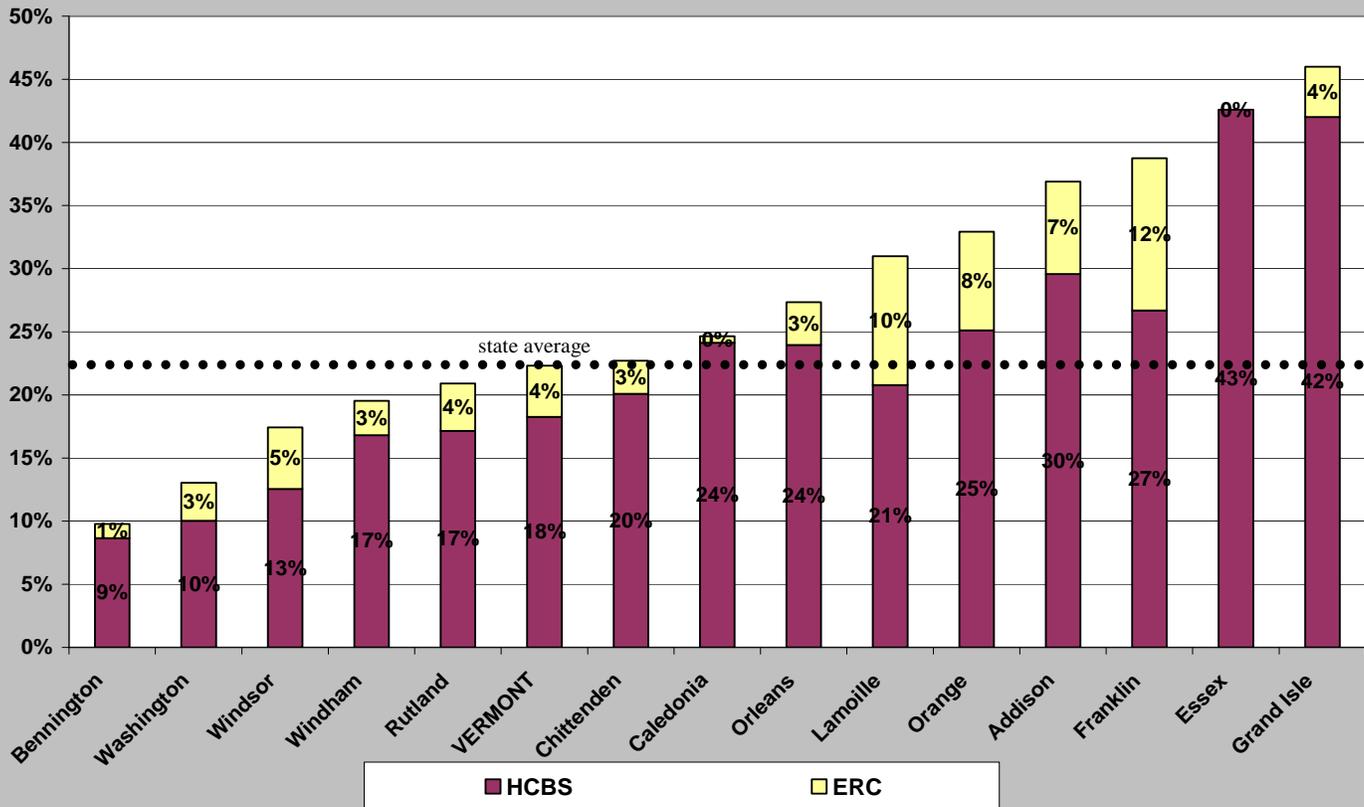
This graph provides a demographic perspective on Choices for Care nursing home enrollment in each county, based on estimates of total demographic need. The data do not include the Moderate Needs Group.

The chart is based on *Shaping the Future of Long Term Care and Independent Living 2006-2016* by Julie Wasserman (May 2007), which includes two estimates of need: 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 currently served, producing an estimate of the percentage of people in need who are actually served.

Note that this estimate of need includes all income groups- including people who will never be financially eligible for long term care Medicaid or Choices for Care. It also includes people who are currently served through 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, this graph does provide a demographic perspective on the relative percentages of people served in each county.

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

Aged 18+, all income groups, including NF residents, 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*

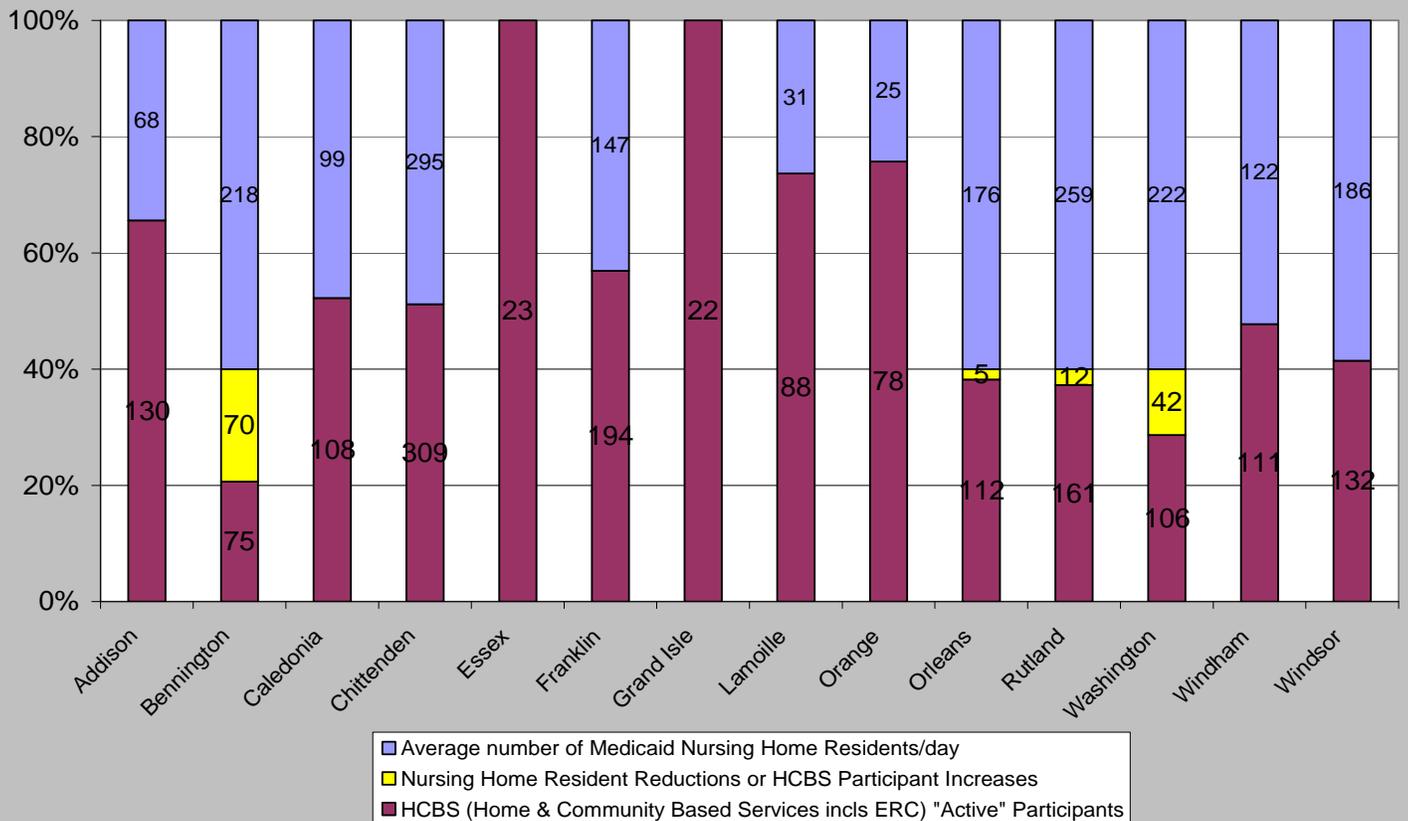
This graph provides a different demographic perspective on Choices for Care enrollment in each county, with a focus on alternative settings. The data does not include people enrolled in the Moderate Needs Group.

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 2006-2016*, 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, this estimate of need includes all income groups- including people who will never be financially eligible for long term care Medicaid or Choices for Care. It is not reasonable to attempt to serve 100% of this estimated need through Choices for Care. This graph does illustrate the relative percentages of people served in community settings within each county.

In looking at the two preceding graphs, one sees that some counties (e.g. Addison, Orange) serve a high percentage in the HCBS/ERC setting; some counties (eg Bennington, Washington) serve a high percentage in the nursing home setting; and some counties (eg Franklin) serve a high percentage of the population in both settings.

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



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

One of the expected outcomes of *Choices for Care* is that a higher percentage of people using 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 July 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). This is based on a performance “benchmark” for at least 40% of the people who use Medicaid long term care in each county to be served in a home and community-based setting.

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

A number of surveys (e.g. AARP) have found that people express a preference for home and community-based services over nursing home services. This is consistent with a core concept in Choices for Care: if people are given choice among the different Medicaid LTC service options, they will tend to choose home and community-based options. If this is true, increased use of home and community-based services should be correlated with decreased use of nursing homes. While this has been observed at a statewide level, the variation among Vermont counties has not been closely examined.

Using Medicaid claims data for the period October 2005 - June 2007, DAIL Division of Disability and Aging Services, Information and Data Unit staff produced Pearson product correlation coefficient values to determine the relationships between the use of the three service options in each Vermont county. A positive value means that use of two different settings is positively correlated, i.e. both increasing, both decreasing, or both remaining stable. A negative value means that the use of two different settings is negatively correlated, i.e. one increasing and the other decreasing. As values approach the maximum value of 1.0, there is stronger evidence of a consistent relationship.

Correlations in Use of NH, HCBS and ERC: Oct. 2005 - June 2007

		ERC	HCBS (exc. MNG)	NF bed changes
ADDISON	HCBS	0.796	X	
	NH	-0.385	-0.345	
BENNINGTON*	HCBS	0.613	X	
	NH	-0.267	-0.612	
CALEDONIA*	HCBS	NA	X	
	NH	NA	-0.846	
CHITTENDEN*	HCBS	-0.001	X	-42
	NH	0.072	-0.838	Oct. 2006
ESSEX**	HCBS	NA	X	
	NH	NA	-0.181	
FRANKLIN	HCBS	0.910	X	
	NH	-0.251	-0.100	
GRAND ISLE**	HCBS	NA	X	
	NH	NA	0.234	
LAMOILLE*	HCBS	0.844	X	-90
	NH	-0.902	-0.897	Feb. 2007
ORANGE	HCBS	0.484	X	10
	NH	0.699	0.585	Sep. 2006
ORLEANS	HCBS	0.890	X	-10
	NH	0.359	0.167	Oct. 2005
RUTLAND	HCBS	0.618	X	
	NH	-0.141	-0.369	
WASHINGTON*	HCBS	0.486	X	
	NH	-0.573	-0.257	
WINDHAM	HCBS	-0.069	X	
	NH	-0.418	0.057	
WINDSOR*	HCBS	-0.643	X	-8
	NH	-0.829	0.684	Jan. 2006
STATEWIDE*	HCBS	0.921	X	
	NH	-0.804	-0.929	
* 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 Lamoille, Washington, and Windsor Counties. This means that in these counties, increased use of ERC was associated with a similar decrease in the use of NH. The use of HCBS and NH groups was significantly negatively correlated in Bennington, Caledonia, Chittenden and Lamoille Counties. This means that in these counties, increased use of HCBS was associated with a similar decrease in the use of NH.

Nursing home capacity is one obvious factor in actual nursing home use. Increased use of home and community-based services may contribute to bed reductions. Conversely, bed reductions can be expected to result in reduced use of nursing homes and increased use of home and community-based services. As illustrated in the preceding table, the number of available nursing home beds was reduced in Chittenden, Lamoille, and Windsor Counties. Increased use of home and community-based services was directly associated with decreased use of a constant number of nursing home beds in just three counties: Bennington, Caledonia, and Washington. The future relationship between the growing use of home and community-based services and nursing home capacity in these counties is unknown.

Decreased Use of Home and Community-Based Services, Decreased Use of Nursing Homes:

In only one county- Windsor- the use of HCBS decreased during nearly two years of Choices for Care. Note that the use of NF services decreased at a similar rate, while the use of ERC increased at a similar rate. This suggests that increased use of ERC may have contributed to reduced use of NF in Windsor County.

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

There were no significant relationships between the use of ERC and NH in Addison, Bennington, Caledonia, Chittenden, Essex, Franklin, Grand Isle, Orleans, or Rutland Counties. There were no significant relationships between the use of HCBS and NH in Addison, Essex, Franklin, Grand Isle, Orleans, Rutland, Washington, or Windham Counties. The increased use of home and community based services was not correlated with decreased use of nursing homes.

The use of HCBS and NH was significantly correlated in a positive direction in Orange County. The use of both services grew at a similar rate in this county over the 21 month period. The use of ERC and HCBS was significantly correlated in a positive direction in Addison, Bennington, Franklin, Lamoille, Orange, Orleans, Rutland and Washington Counties. In short, the use of ERC and HCBS settings grew at similar rates in these eight counties during the 21 month period.

Conclusion

While the causal relationships between measures remain unproven, there is some evidence that increased use of home and community-based services was associated with decreased use of nursing homes. In six counties (Bennington, Caledonia, Chittenden, Lamoille, Washington, and Windsor), increased use of home and community-based alternatives was significantly correlated with decreased use of nursing home services. In three of these counties (Chittenden, Lamoille, and Windsor), increased use of home and community-based alternatives was associated with a reduction in the number of licensed nursing home beds. In eight counties (Addison, Essex, Franklin, Grand Isle, Orange, Orleans, Rutland, and Windham), increased use of home and community-based alternatives was not significantly correlated with decreased use of nursing home services.

Some observers have questioned if there is a relationship between the costs of plans of care and the use of nursing homes. This is based on the hypothesis that higher POC costs are now necessary to support people in the community.

As a test of this hypothesis, counties were ranked on the average HCBS plan of care (POC) cost and demographic use of nursing homes. Lower POC cost was assigned higher positive scores, while greater reliance on nursing homes was assigned higher negative scores. The two scores were added to create a combined rank.

Under this method, low POC costs and low use of nursing homes result in a higher positive combined rank. Conversely, high POC costs and high use of nursing homes result in a higher negative combined rank. The table below shows the rankings for each county:

	<u>combined</u> <u>rank</u>	<u>HCBS</u> <u>POC rank</u>	<u>use of NF</u> <u>rank</u>
Addison	-3	2	-5
Bennington	-7	7	-14
Caledonia	-2	5	-7
Chittenden	-7	1	-8
Essex**	13	14	-1
Franklin	-3	3	-6
Grand Isle**	0	4	-4
Lamoille	4	6	-2
Orange	9	12	-3
Orleans	2	13	-11
Rutland	-1	11	-12
Washington	-4	9	-13
Windham	-1	8	-9
Windsor	0	10	-10

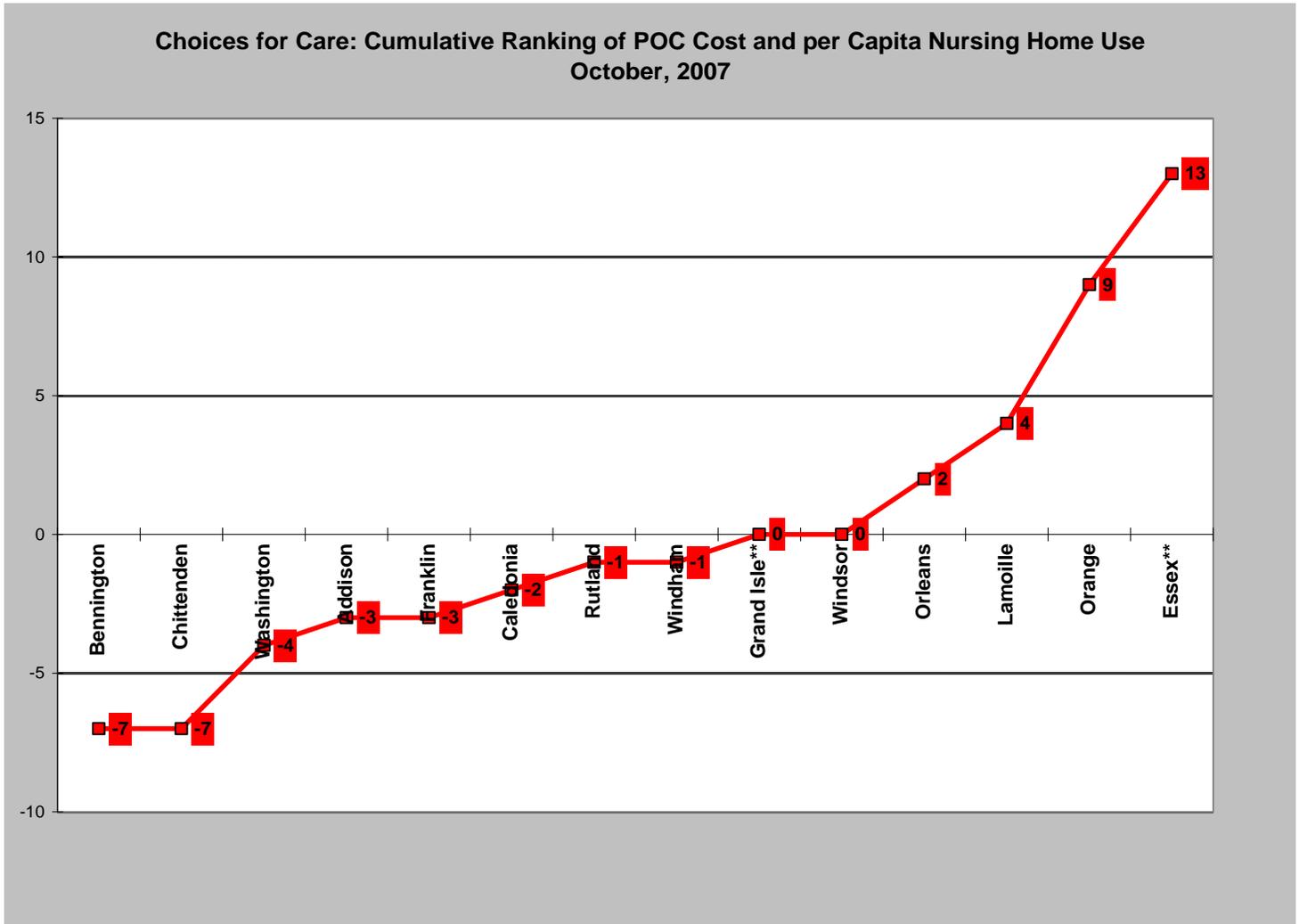
In Essex** and Orange Counties, POC costs were low while use of nursing homes was also low, resulting in high scores. The rankings of these counties suggest that relatively low POC costs can effectively support people in the community. In Bennington County, use of nursing homes was very high while POC costs were near the middle. In Chittenden County, POC costs were very high, while use of nursing homes was near the middle. In Lamoille County, use of nursing homes was very low while POC costs were near the middle. These findings do not support the hypothesis that relatively high POC costs help to support relatively low use of nursing homes.

No county had higher than average POC costs and higher than average nursing home costs. The absence of any counties meeting this condition tends to support the hypotheses.

In Addison, Franklin, and Grand Isle** Counties, POC costs were high while use of nursing homes was low, resulting in moderate scores. In Orleans, Rutland, Washington, Windham, and Windsor Counties, POC costs were low while use of nursing homes was high, resulting in moderate scores. In Caledonia County, POC costs were moderate while use of nursing homes was moderate, resulting in moderate scores. These findings, representing a majority of the counties, do support the hypothesis that relatively high POC costs help to support relatively low use of nursing homes.

*** no nursing homes within the county*

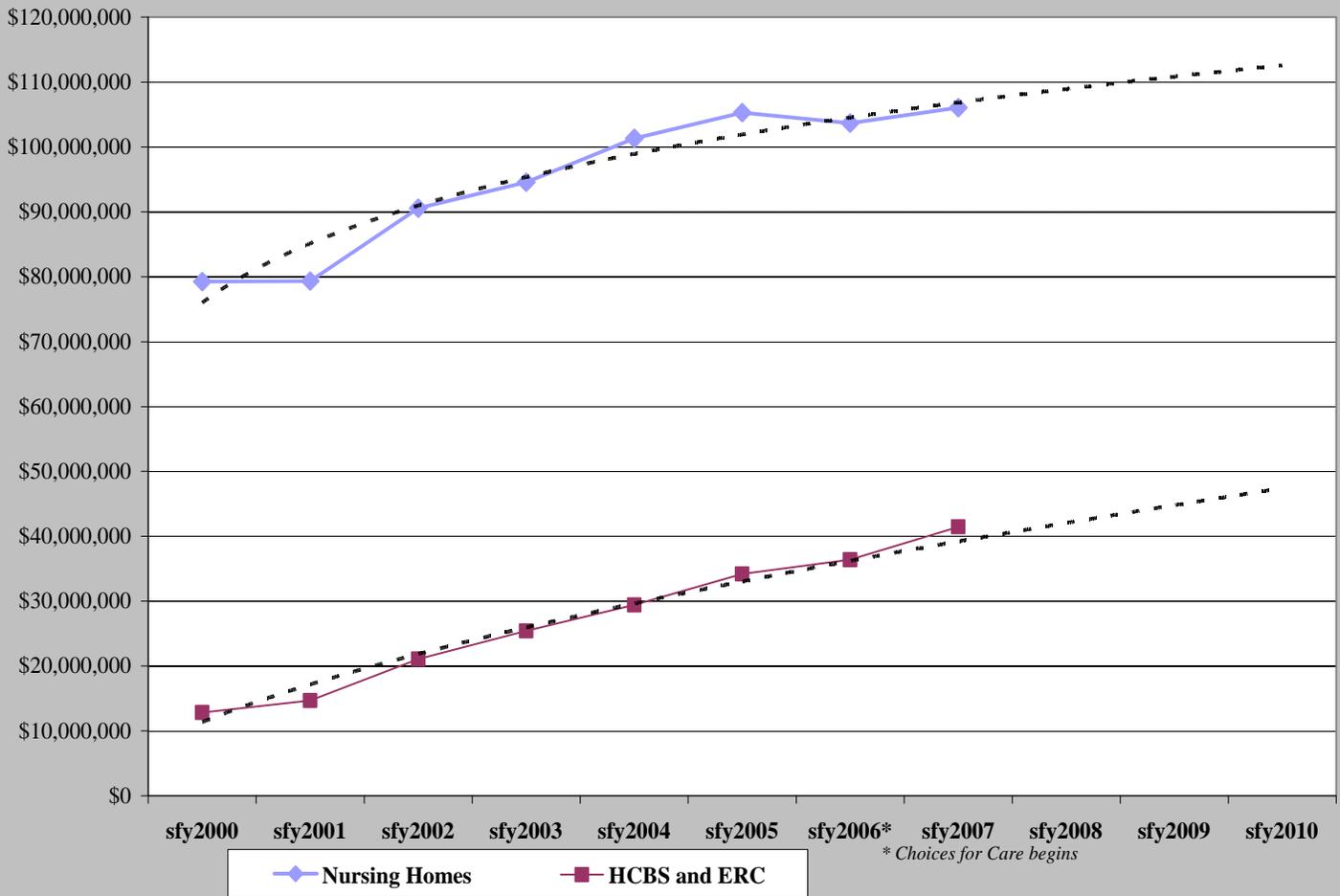
This graph illustrates the combined rank for each county:



Data sources: DAIL/DDAS SAMS database, *Shaping the Future*.

** no nursing homes within the county

Vermont LTC Expenditures by Type, sfy2000-sfy2007

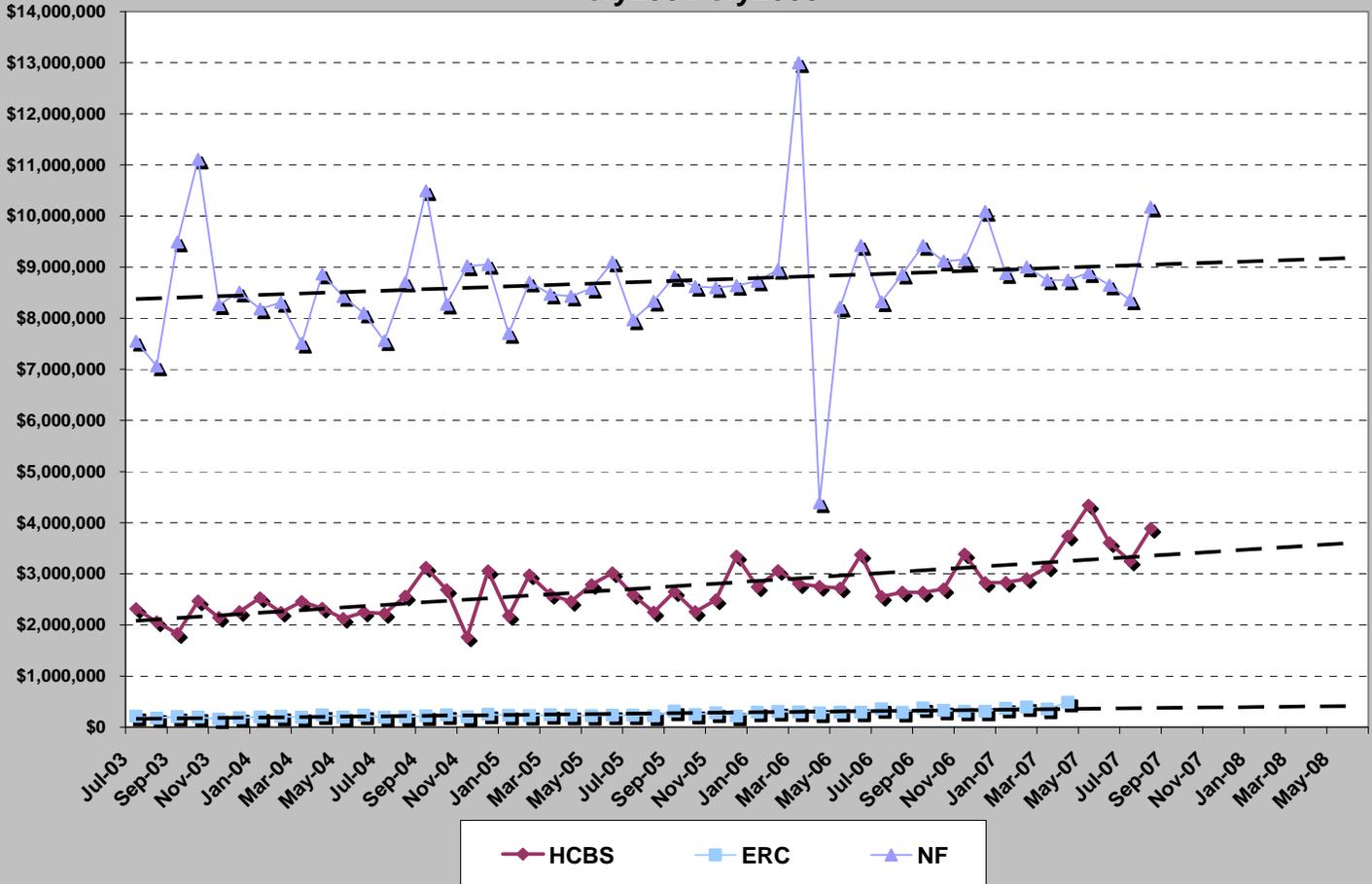


Data source: DAIL Monthly Monitoring Report

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

Vermont Long Term Care: Monthly Expenditures by Category sfy2004-sfy2008



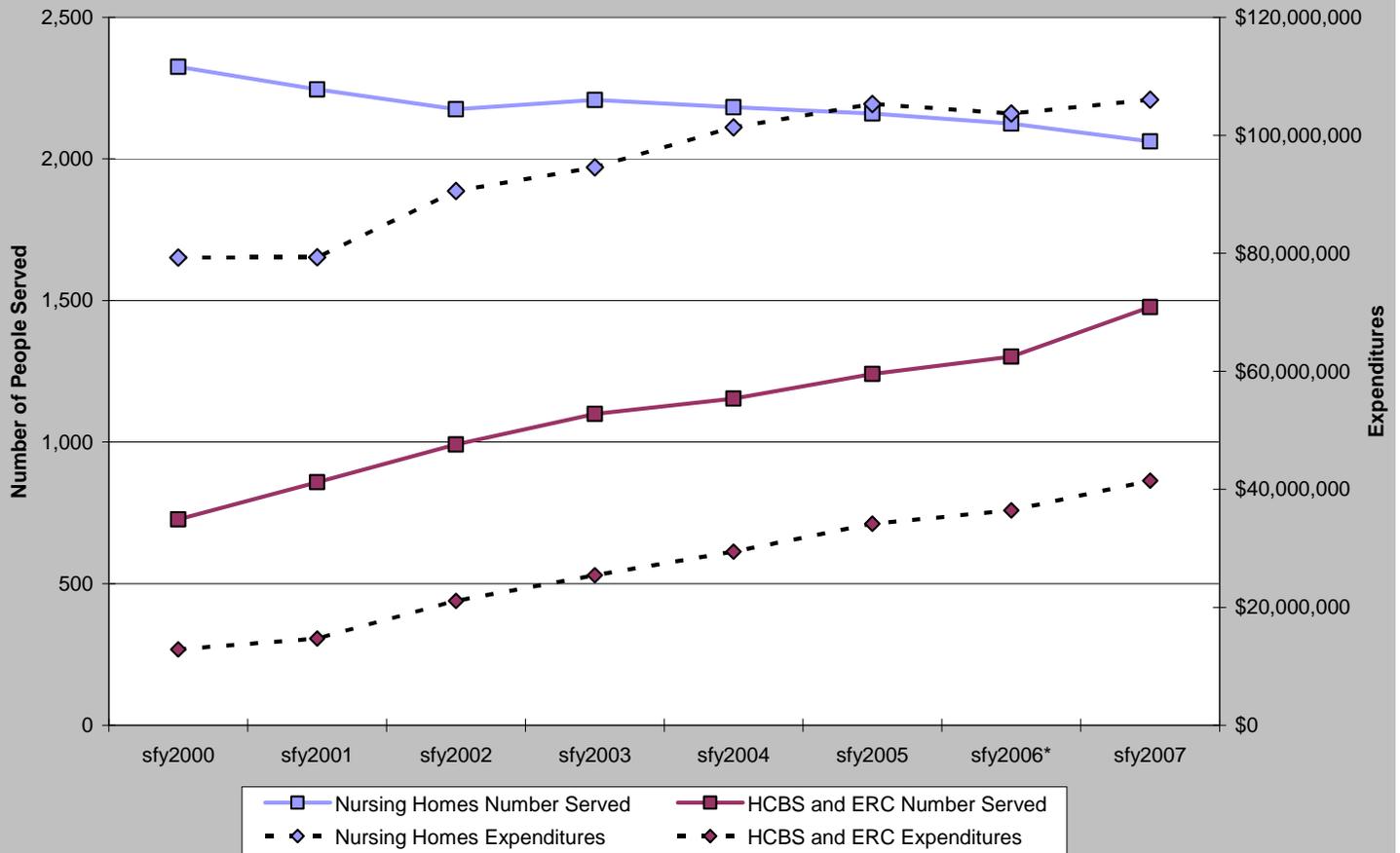
Data source: DAIL Monthly Monitoring Report.

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 all 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 more than expenditures in the other settings 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 increased about 3%.

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

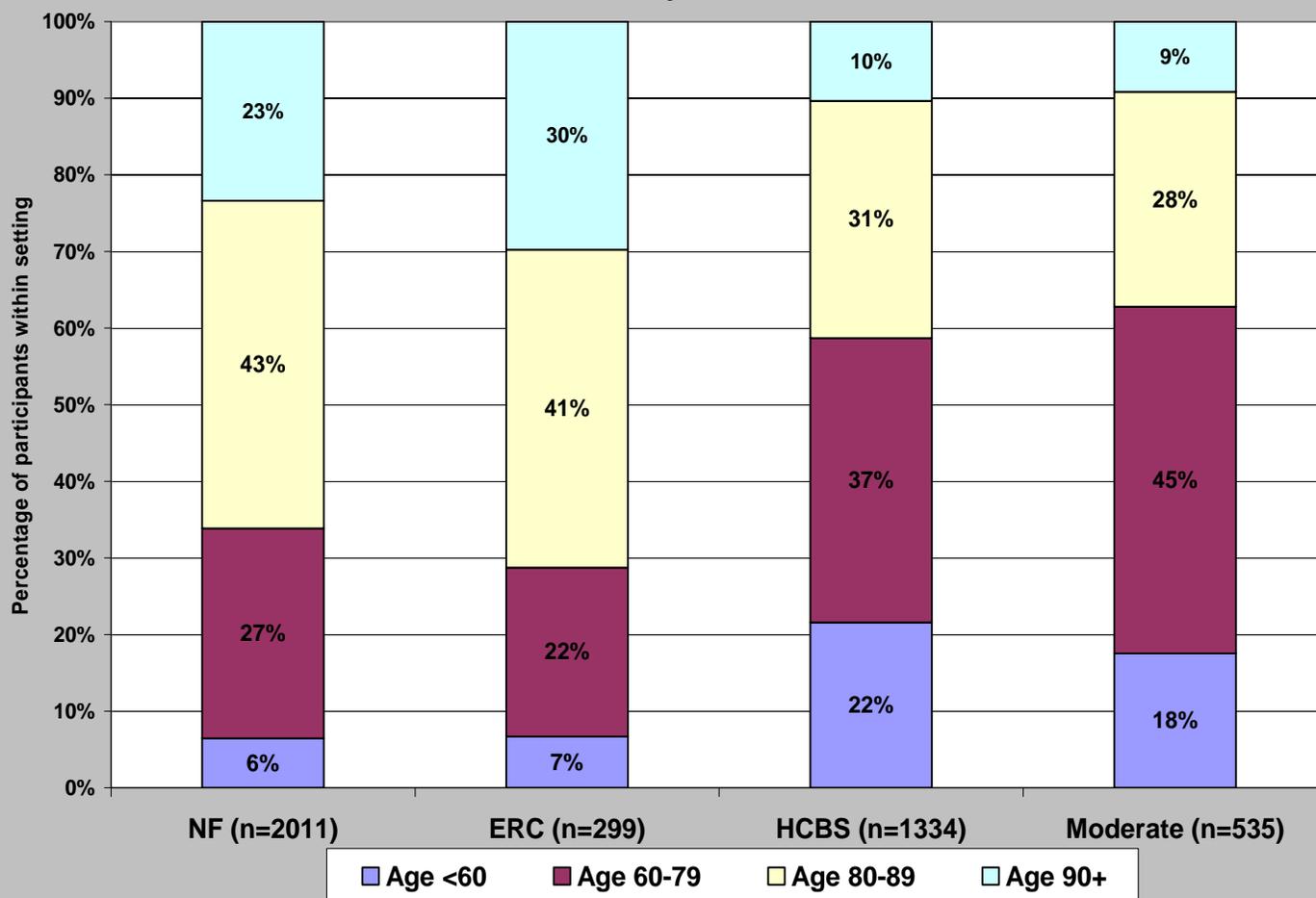


Data sources: DAIL/DDAS SAMS database; DAIL Monthly Monitoring Report

This graph 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.

The different increases are related to the different trends in services: the number of people served in nursing homes has decreased, while the number served in alternative settings has increased substantially.

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



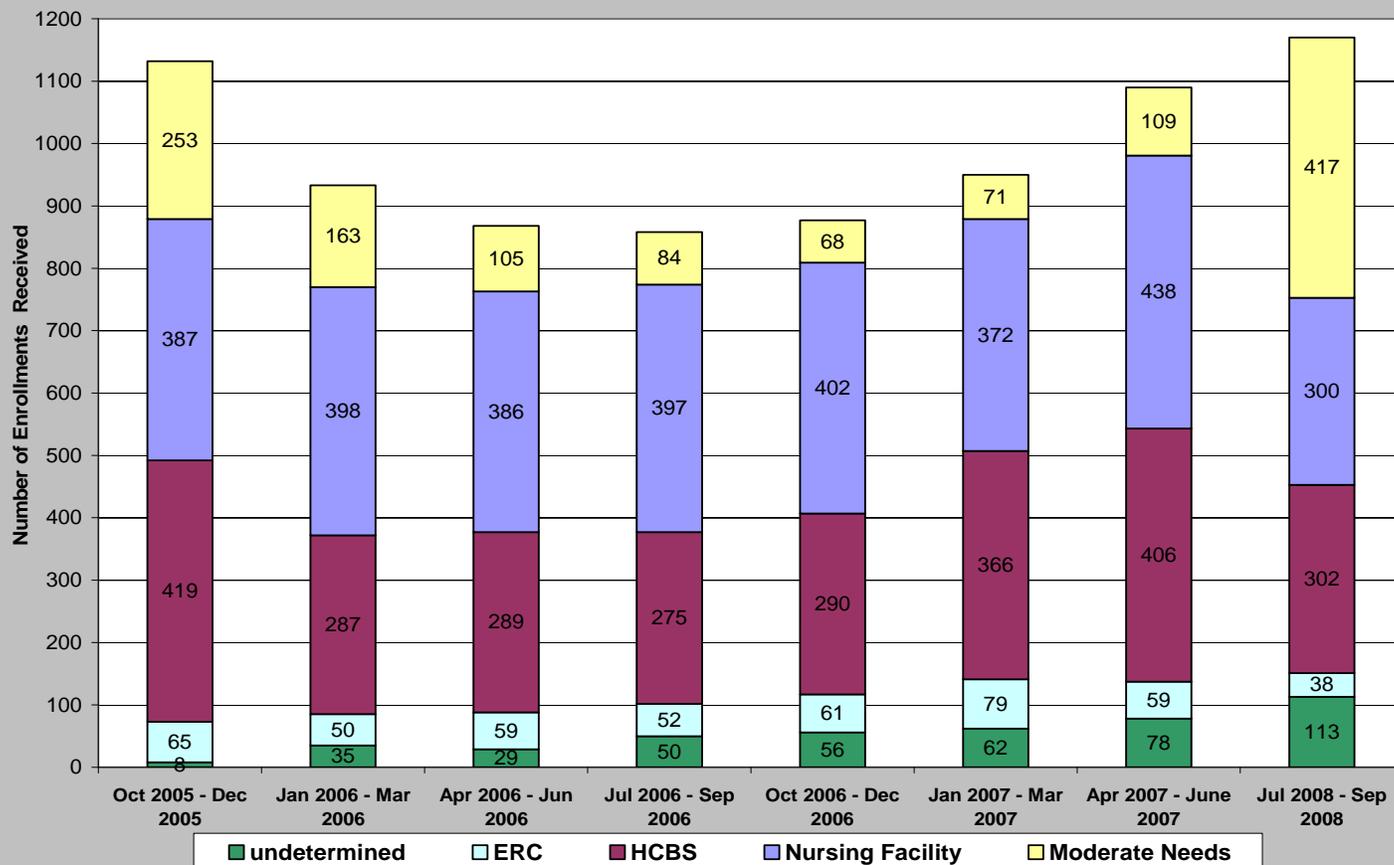
Data source: DAIL/DDAS SAMS database.

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 was 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 were aged 80 or older, and nearly 20% aged 90 or over. The highest percentage of people aged 80 and over was found in the Enhanced Residential Care setting, followed by the Nursing Facility setting. The highest percentage of people under the age of 60 was found in the HCBS setting.

**Choices for Care: Enrollments Received by Service Program
October 2005 through September 2007**



Data source: DAIL/DDAS SAMS database.

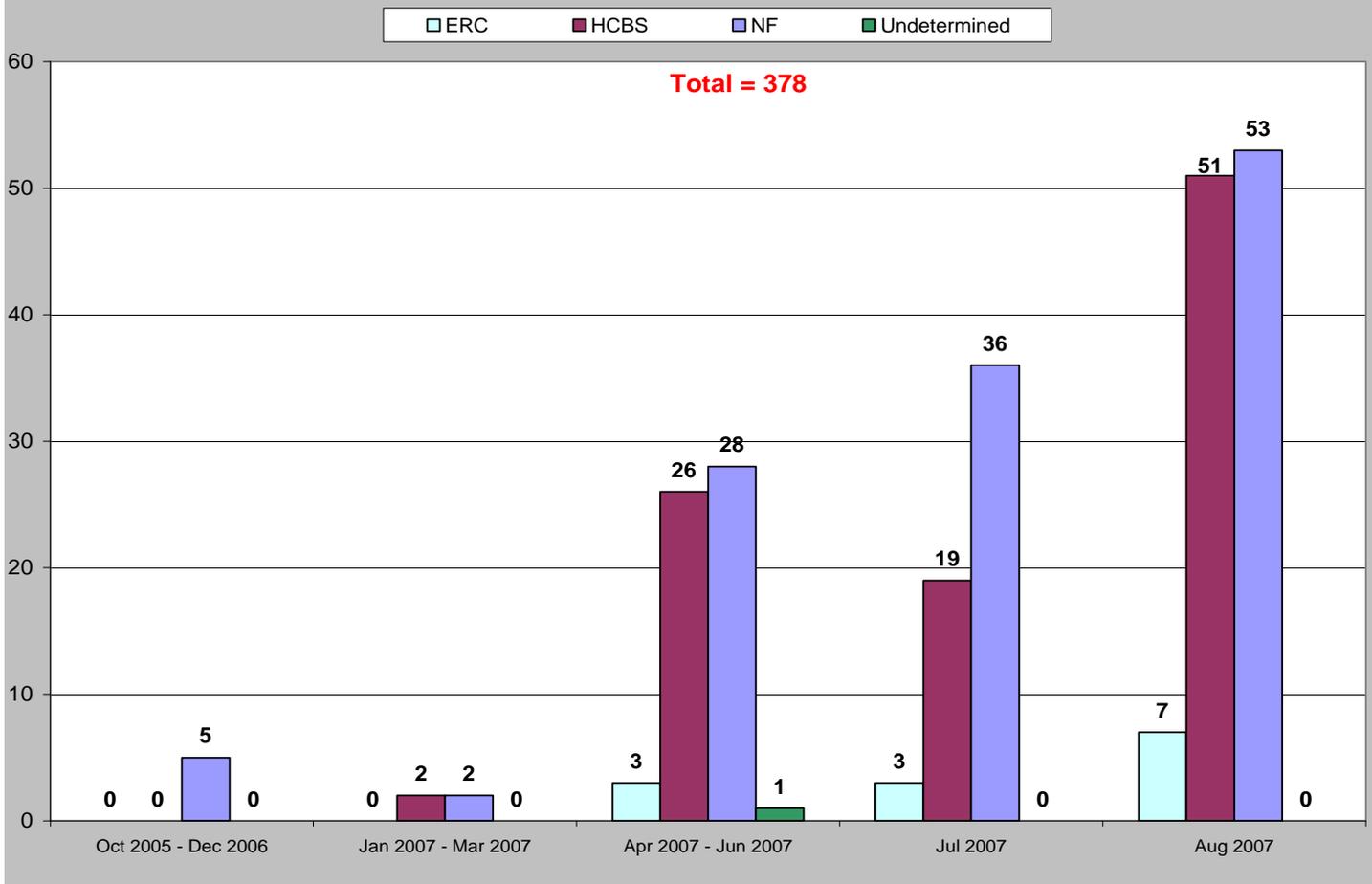
This graph shows the numbers of Choices for Care applications received over time. These data are useful in viewing changes in overall ‘demand’ over time, and in changes in demand among the different settings. They also provide a measure of workload among staff making eligibility decisions at DAIL and at the Department of Children and Families.

The pre-Choices for Care 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. In recent months the number of applications has increased.

DAIL/DDAS currently receives nearly 400 applications each month. Increased funding, transferred from the homemaker program to the Moderate Needs Group, caused an increase in the volume of Moderate Needs Group applications in the initial months of sfy2008.

Nearly 40% of applications were for Nursing Facilities (including short-term and rehabilitation nursing home admissions), and about 35% were for Home and Community-based Services. More than 15% were for Moderate Needs Group, and about 8% for Enhanced Residential Care.

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



Data source: DAIL/DDAS SAMS database.

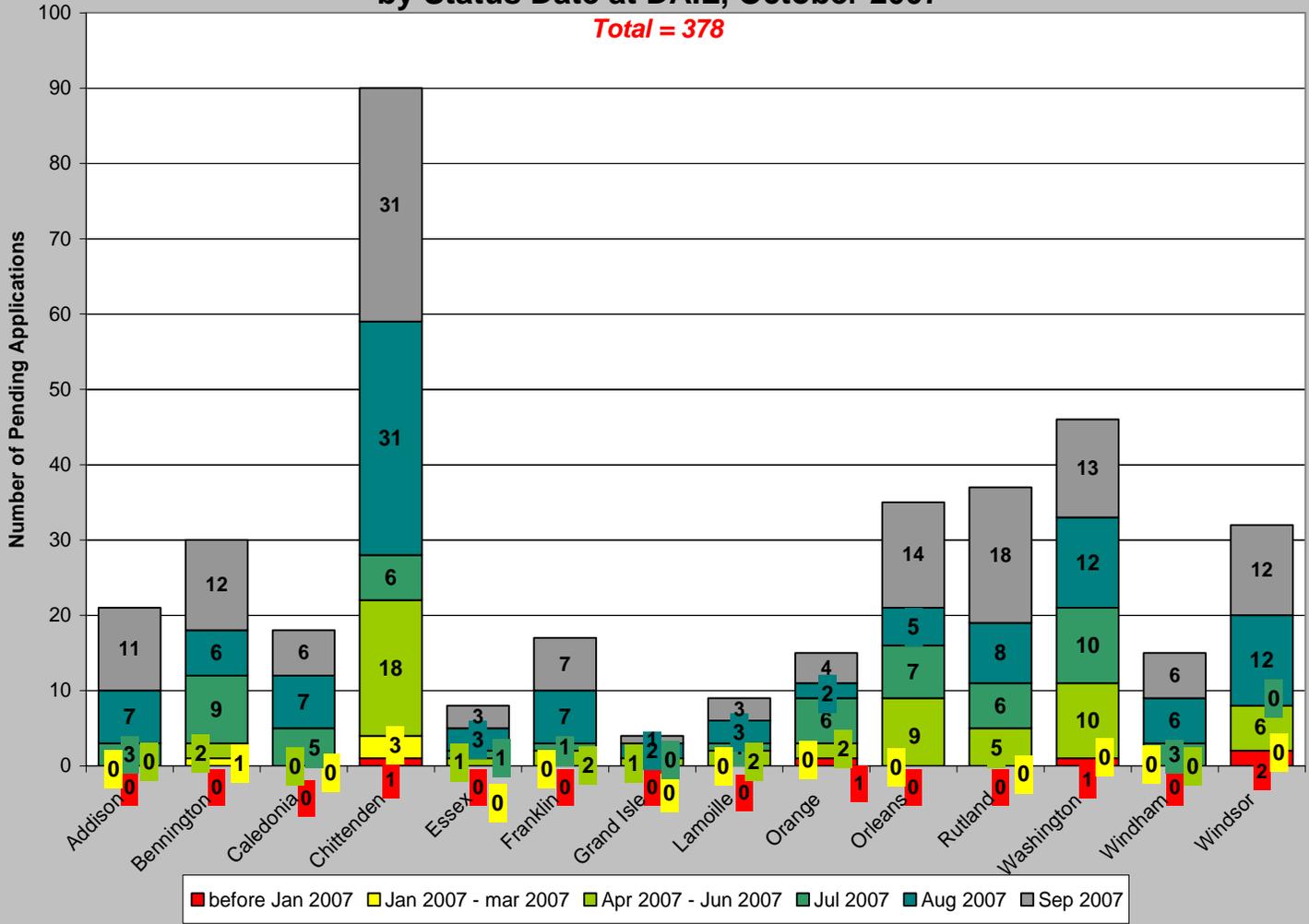
One of the goals of Choices for Care is to help Vermonters access long term care services when they need them. One indicator of success in achieving this goal is the time required to process individual applications. The number of pending applications was over 400 for a number of months; in recent weeks it has decreased slightly, to about 380. 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 remain 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, October 2007

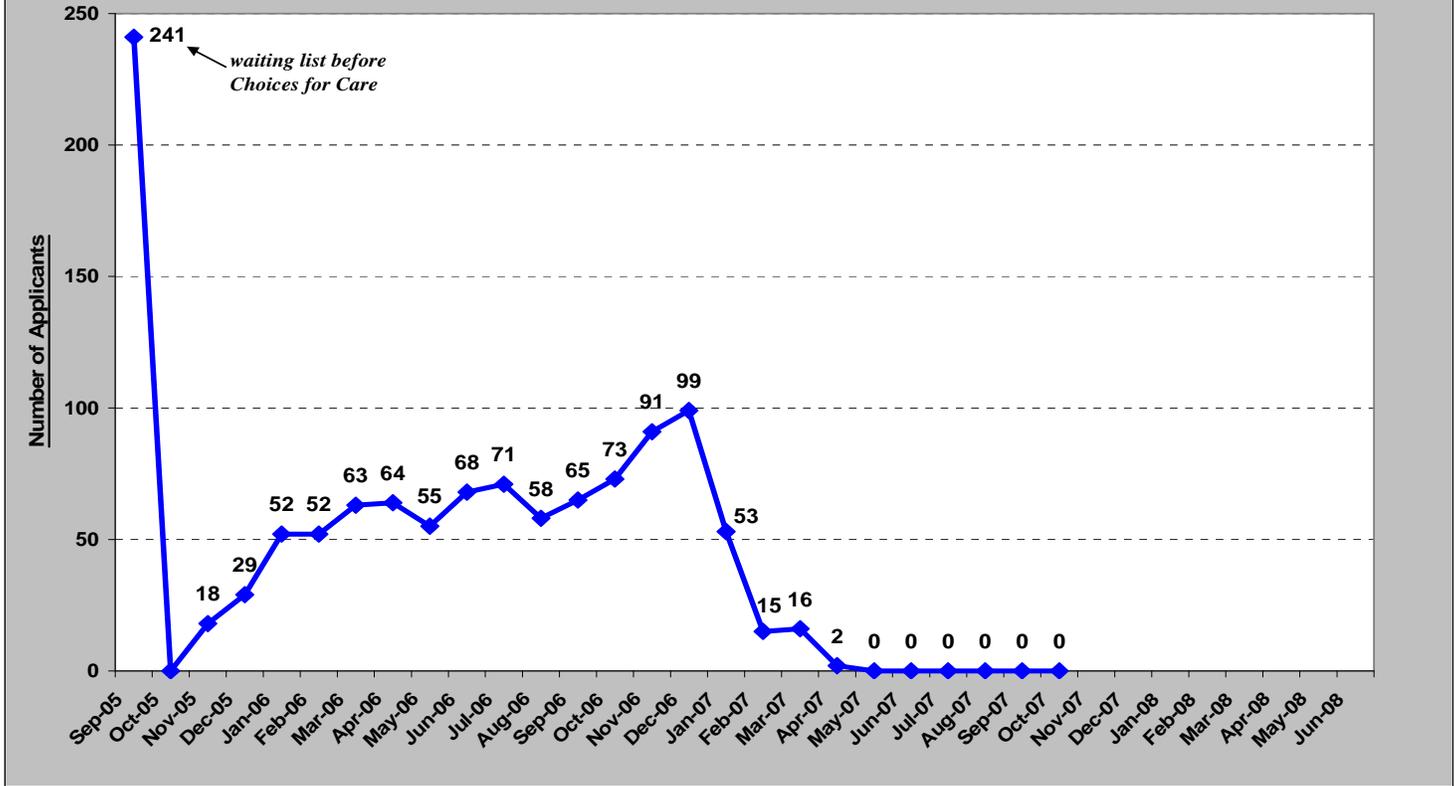
Total = 378



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, Orleans and Washington counties appear to have high percentages of “old” applications.

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



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. 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 other states, waiting lists are long, and getting longer:

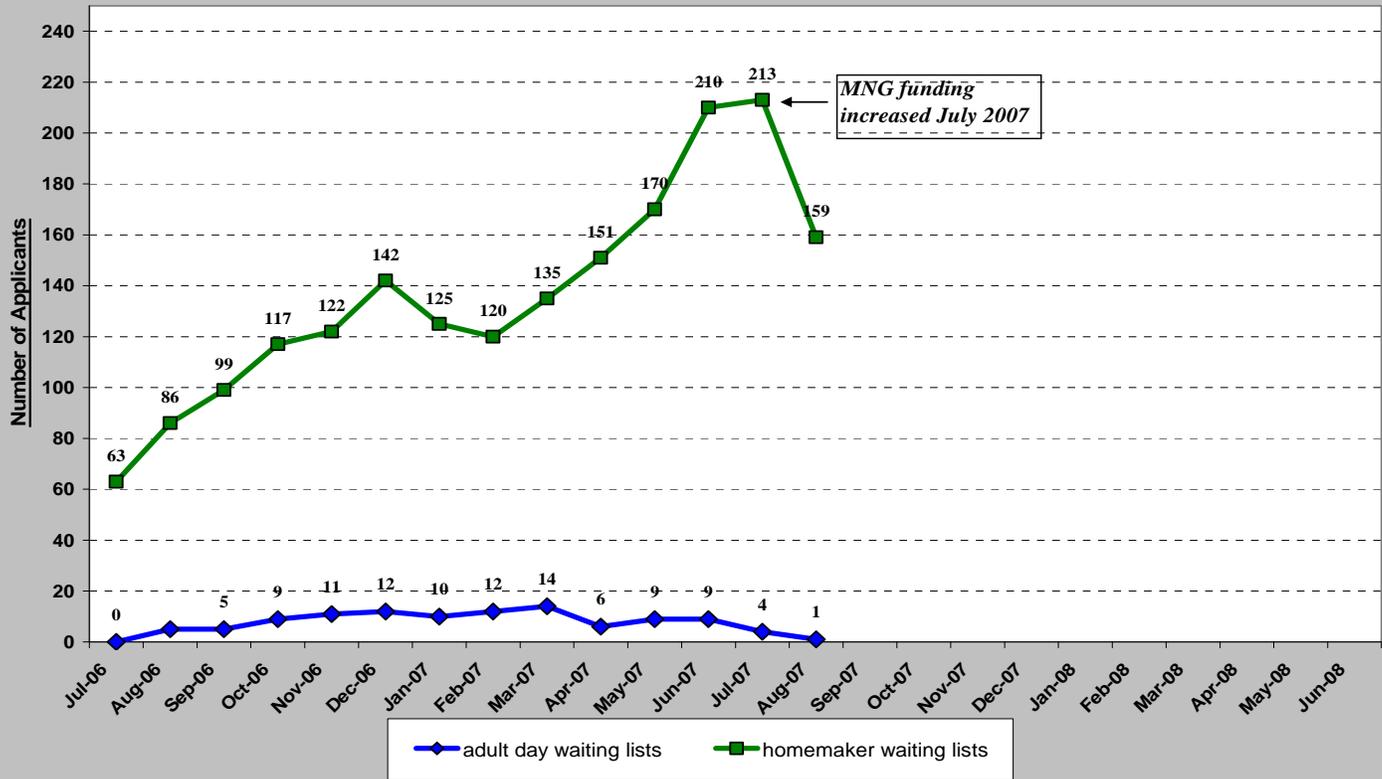
In 2005, 260,916 individuals were on waiting lists for 102 waivers in 30 states, up from 206,427 individuals in 2004. The average length of time an individual spends on a waiting list ranges from 13 months for aged/disabled waivers to 26 months for MR/DD waivers.

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 meet 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 since fallen to zero. In the future, expenditure trends and the availability of funds will continue to drive decisions regarding High Needs enrollment and the High Needs waiting list.

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



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

This graph shows the numbers of people 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. This appears to be related to a higher demand for Homemaker services in relation to available resources.

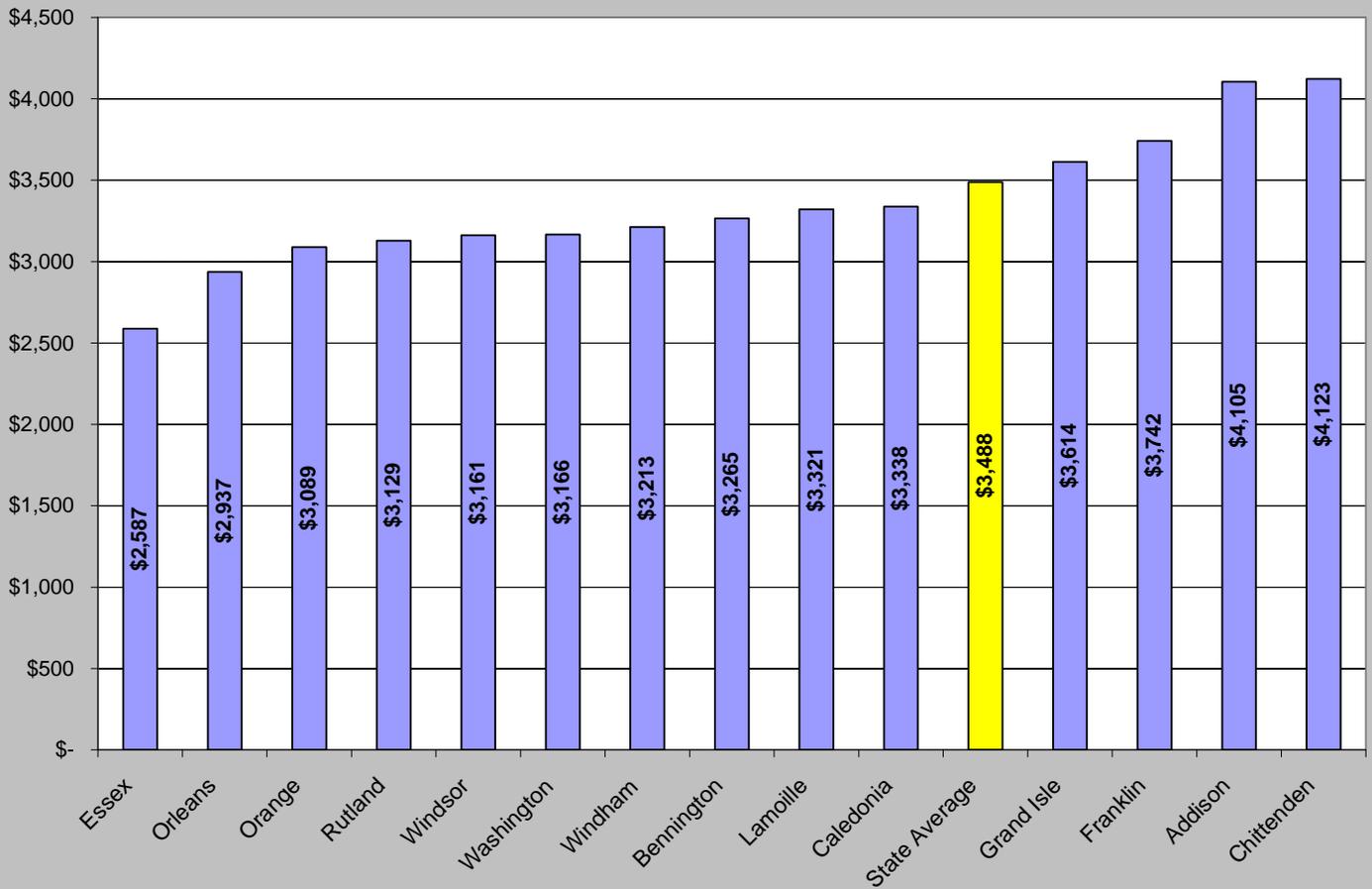
Of the thirteen Adult Day providers, a maximum of four reported waiting lists in any single month. Waiting lists ranged from a low of 0 to a high of 8. Only one provider reported a waiting list in August 2007.

Of the twelve Homemaker providers, a maximum of seven reported waiting lists in any single month. Waiting lists ranged from a low of 0 to a high of 127. While four providers reported substantial waiting lists in August 2007 (13-65), it appears that at least three of these providers may have had funds available to provide additional services. Beyond overall funding levels, these data suggest that secondary factors contribute to Homemaker waiting lists. Two factors have been identified during discussions with providers:

1. Reimbursement: Some providers report that the costs of providing these services are substantially higher than the reimbursement rate of \$18.68/hour and may limit the number of hours of service that they are able to provide. This may be affected by the credentials of the staff that some agencies use to provide the services, and their wage rates.
2. Staffing: Some providers report challenges in recruiting and retaining adequate numbers of Homemaker staff.

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

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



Data source: DAIL/DDAS SAMS database.

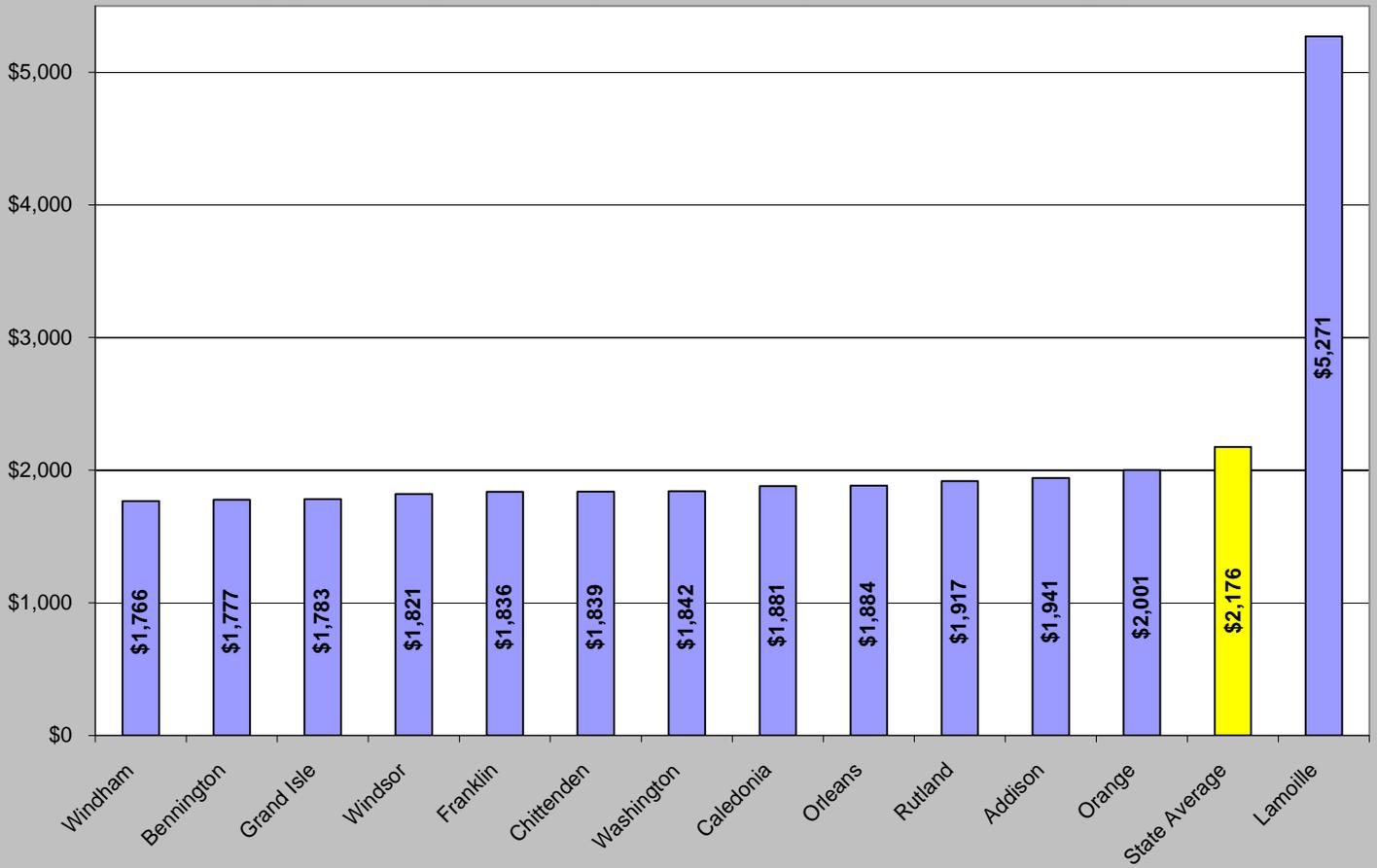
The average approved cost of HCBS Highest/High Needs Group Plans of Care was \$3,488. The average costs in Chittenden, Addison, and Franklin Counties were well above the state average. The average cost in Essex and Orleans Counties was well below the state average.

Several factors 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 October 2007

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



Data source: DAIL/DDAS SAMS database.

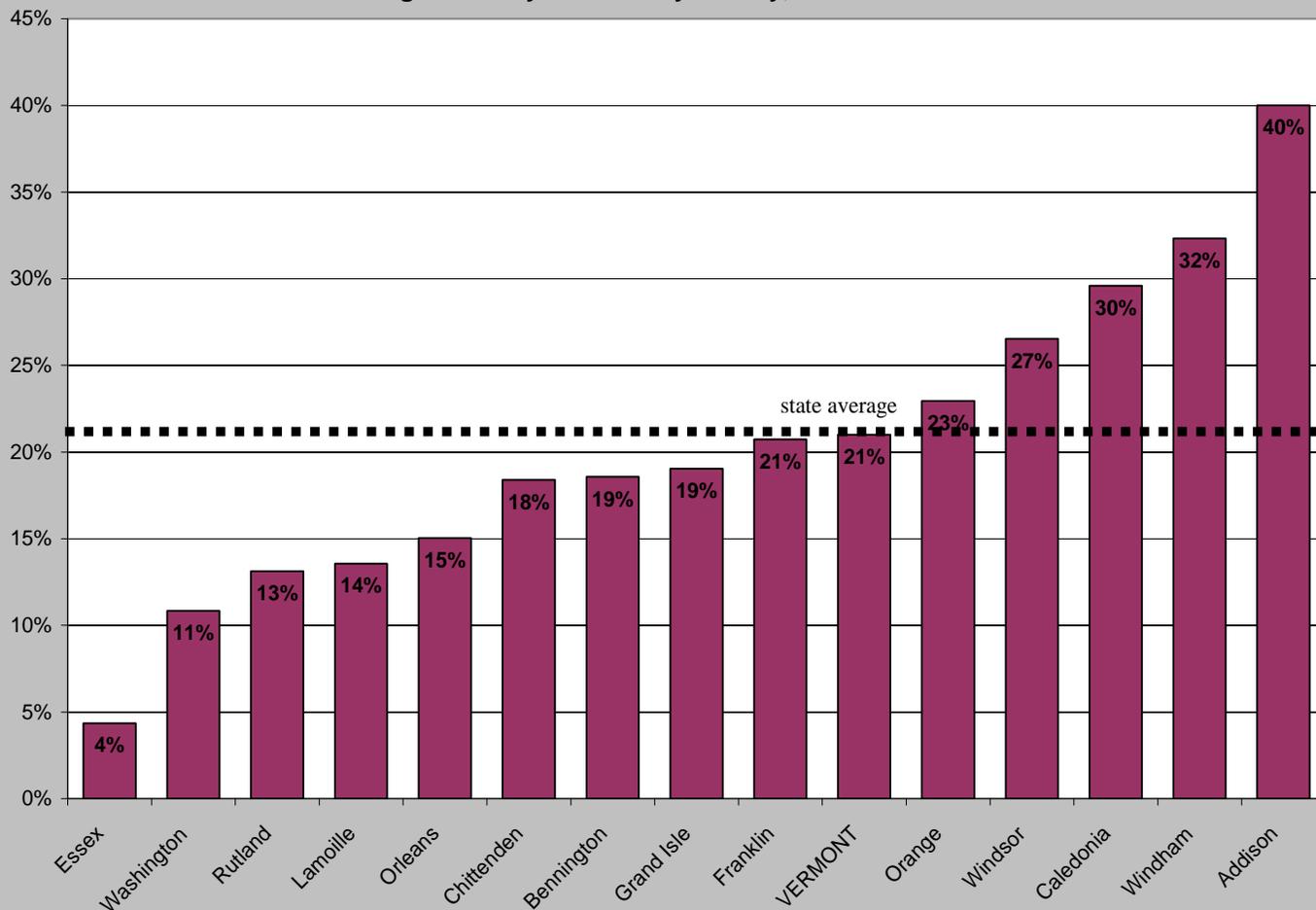
The average approved cost of ERC Highest/High Needs Group plans of care was \$2,165, nearly 40% less than the average approved cost of home-based plans of care.

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

There seems to be no consistent relationship between approved home-based costs and approved ERC costs by county. Addison County had high ERC plan of care costs as well as high home-based plan of care costs. Chittenden and Franklin counties had low ERC plan of care costs but high home-based 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 home-based plan of care costs.

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

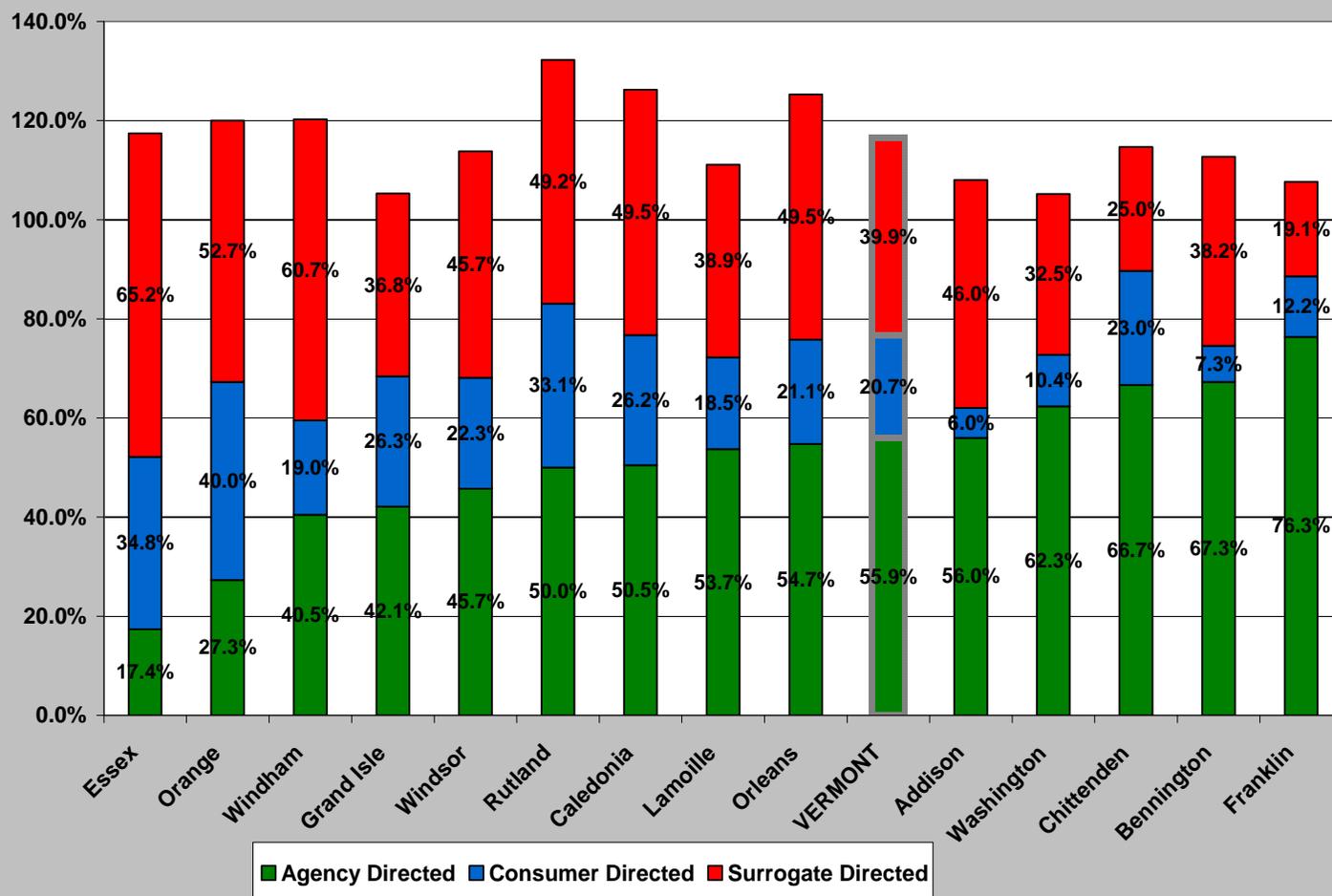


Data source: DAIL/DDAS SAMS database.

This graph 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% of people enrolled in HCBS High/Highest Needs Groups used adult day services, with a range among the counties of 4% to 40%. 30% or more used adult day services in Addison, Windham, and Caledonia Counties. 15% or fewer used adult day services in Essex, Washington, Rutland, Lamoille, and Orleans Counties.

Choices for Care Personal Care Services: Percent of Participants Using Each Option by County, July 2007



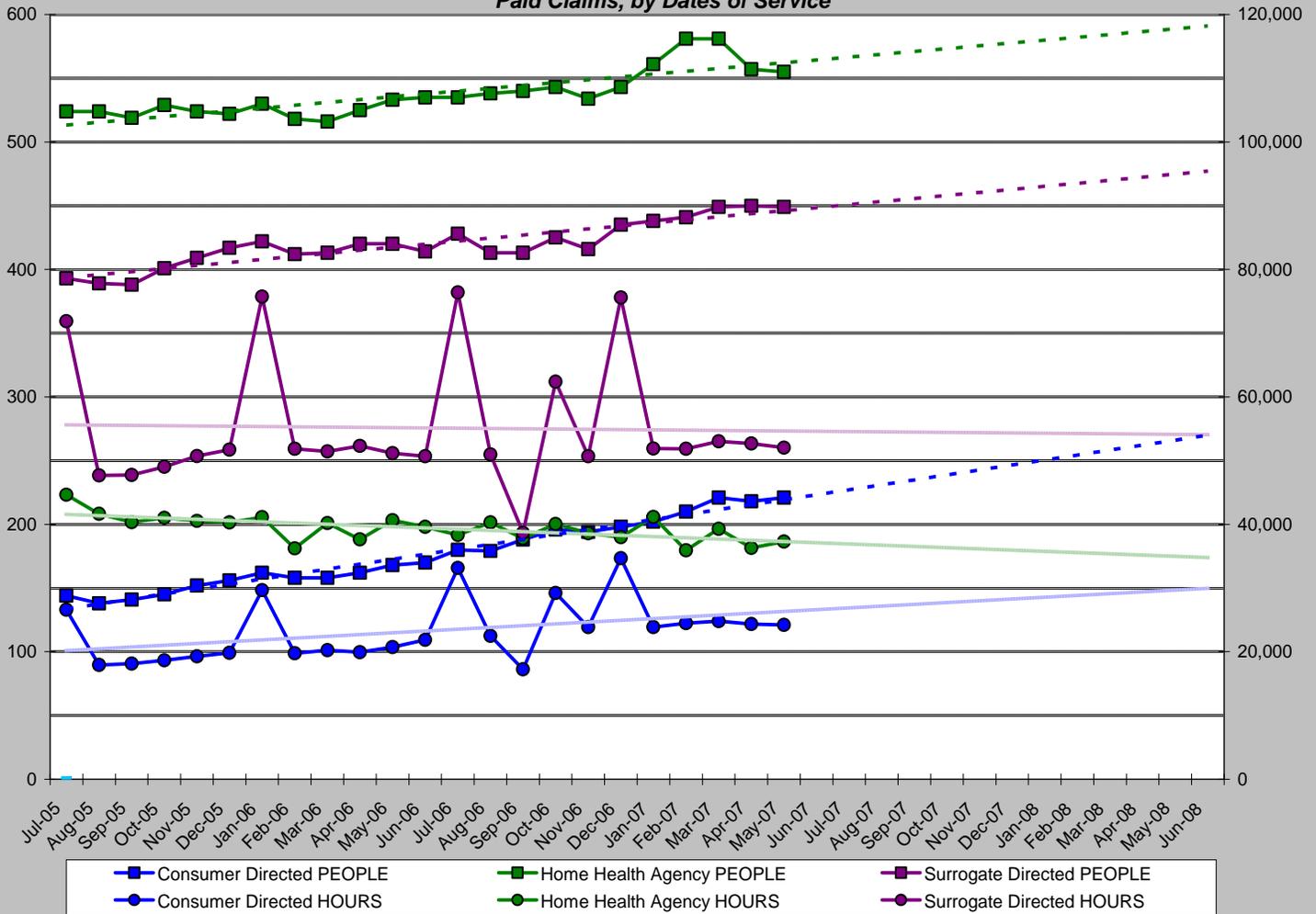
Data source: DAIL/DDAS SAMS database. Includes people who receive more than one type of personal care service.

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 planned 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 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



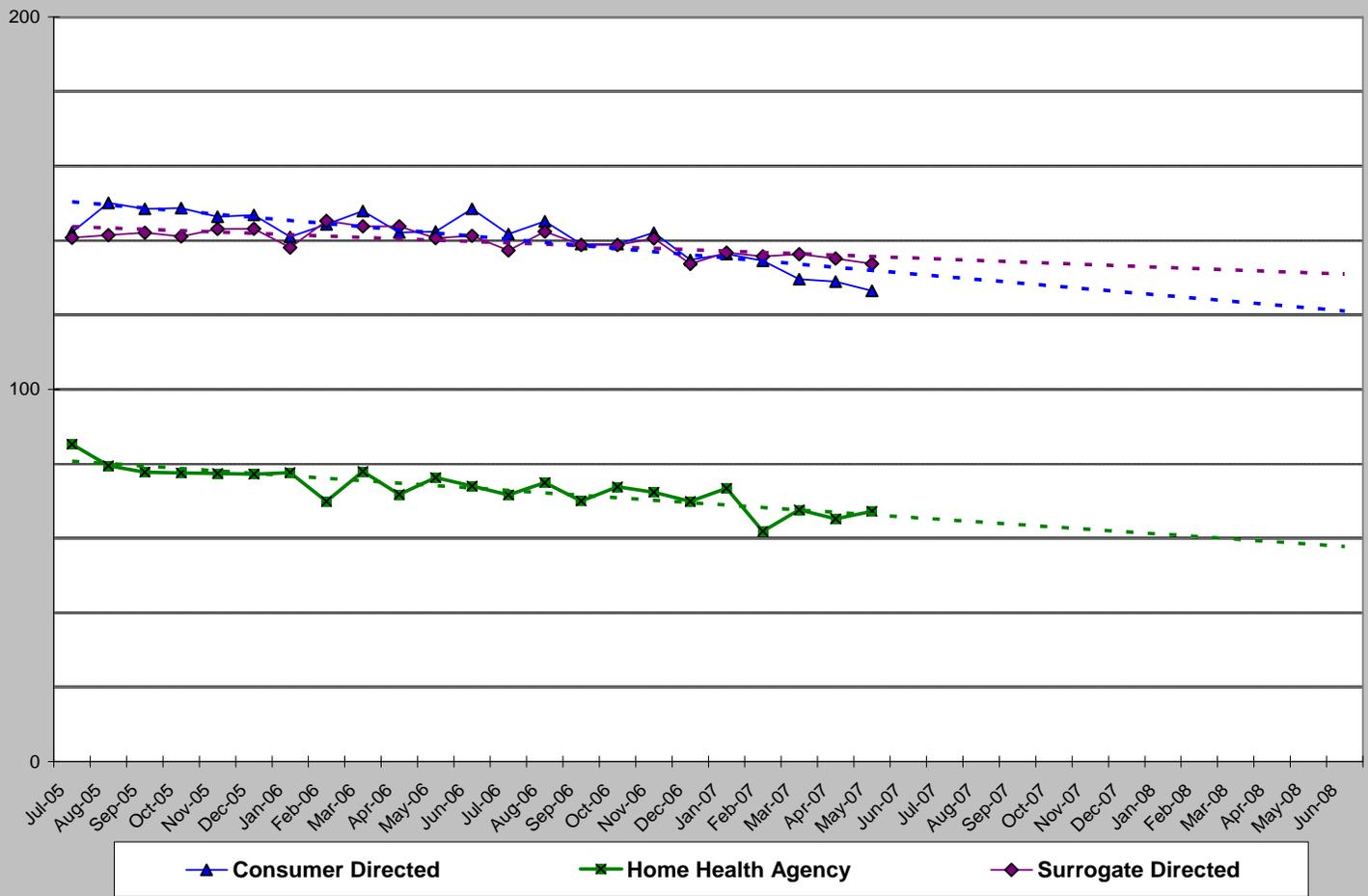
Data source: EDS paid claims, by date of service

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 trends:

<i>option</i>	<i>approx. % of people</i>	<i>People trend</i>	<i>approx. % of services</i>	<i>service trend</i>
Home health	50%	increase	35%	slight decrease
Consumer directed	20%	increase	20%	increase
Surrogate directed	40%	increase	45%	stable

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



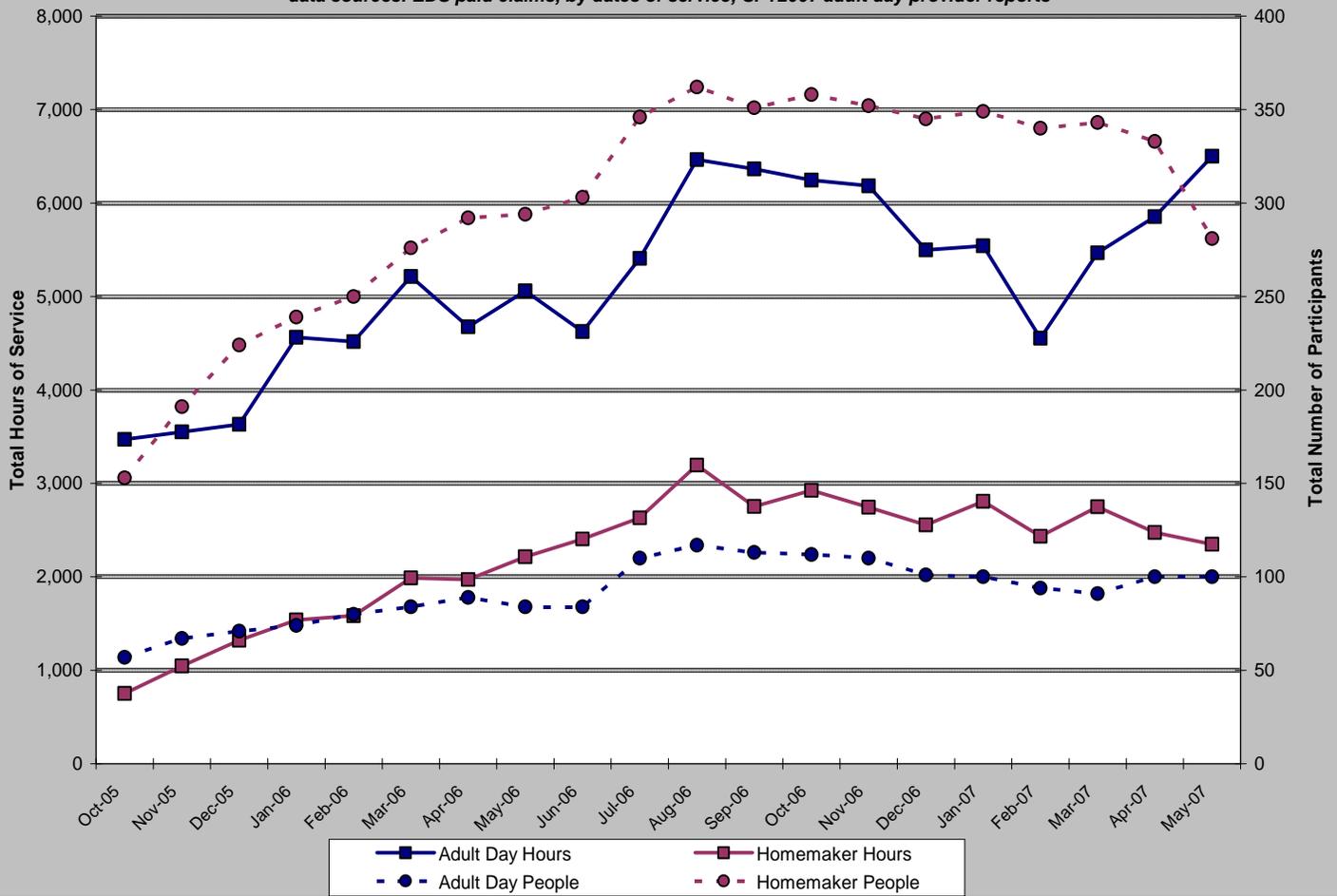
Data source: EDS paid claims, by date of service

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

This graph shows the average number of hours of personal care services that people actually receive each month. The average number of hours provided under each type of service appears to have decreased slightly over the past two years. This is consistent with a small decrease in average POC service hours over the past two years.

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 Moderate Needs Group: Adult Day and Homemaker Services
Number of People Served and Hours of Service, sfy2006-sfy2007
data sources: EDS paid claims, by dates of service; SFY2007 adult day provider reports



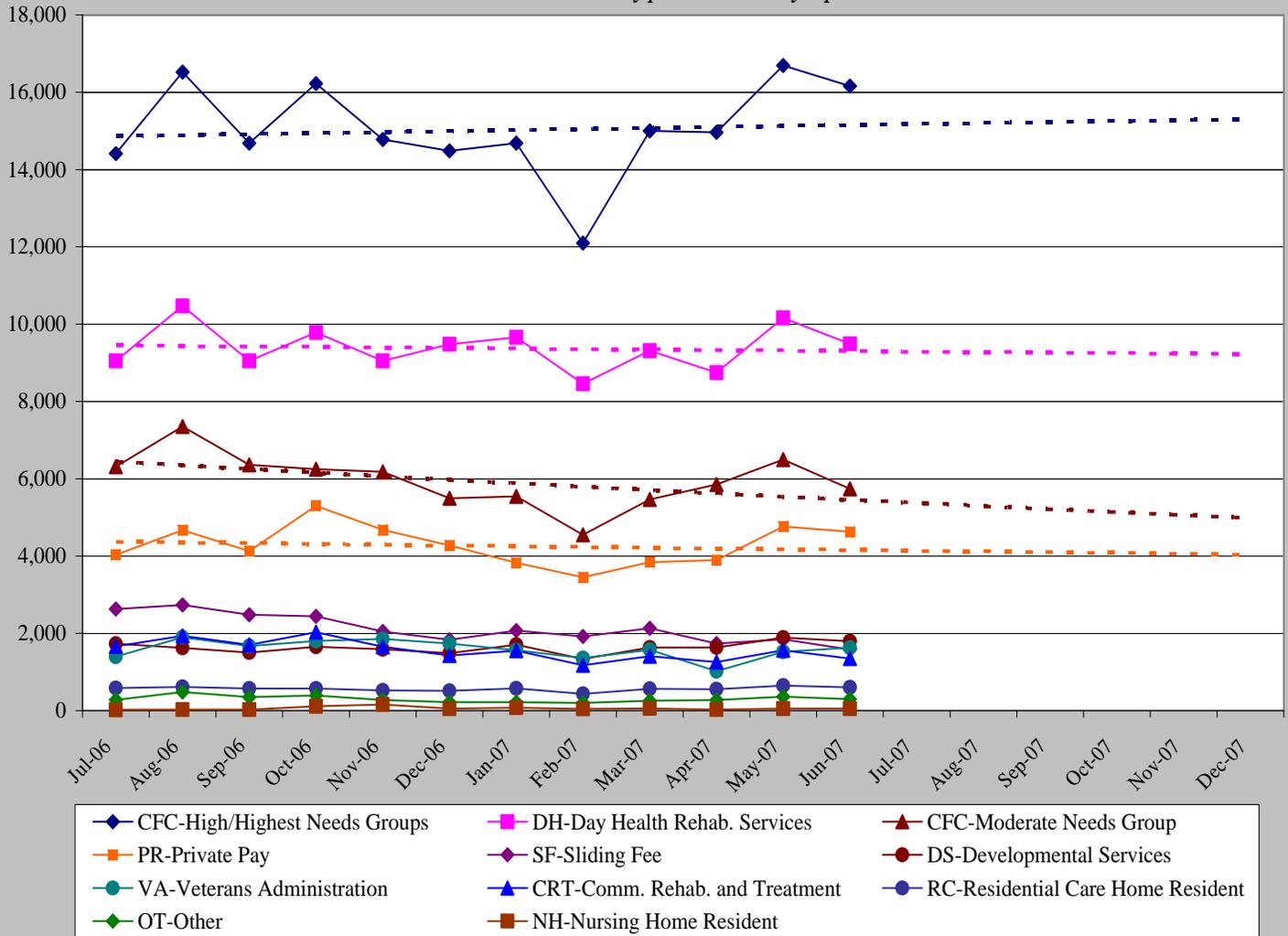
Data source: EDS paid claims, by date of service

This graph shows the patterns in paid Medicaid claims (by dates of service) for the two different Moderate Needs Group services: Adult Day and Homemaker services.

Enrollment in both types of service grew steadily for about a year, and then decreased slightly in calendar year 2007. The monthly number of hours of Homemaker services also decreased slightly. The monthly number of adult day service hours appears to have decreased significantly between November and February, and then increased significantly between November and May. These apparent trends may be influenced by delays in Medicaid enrollment and Medicaid billing.

Adult Day Service Hours by Type, sfy2007

data source: adult day provider monthly reports

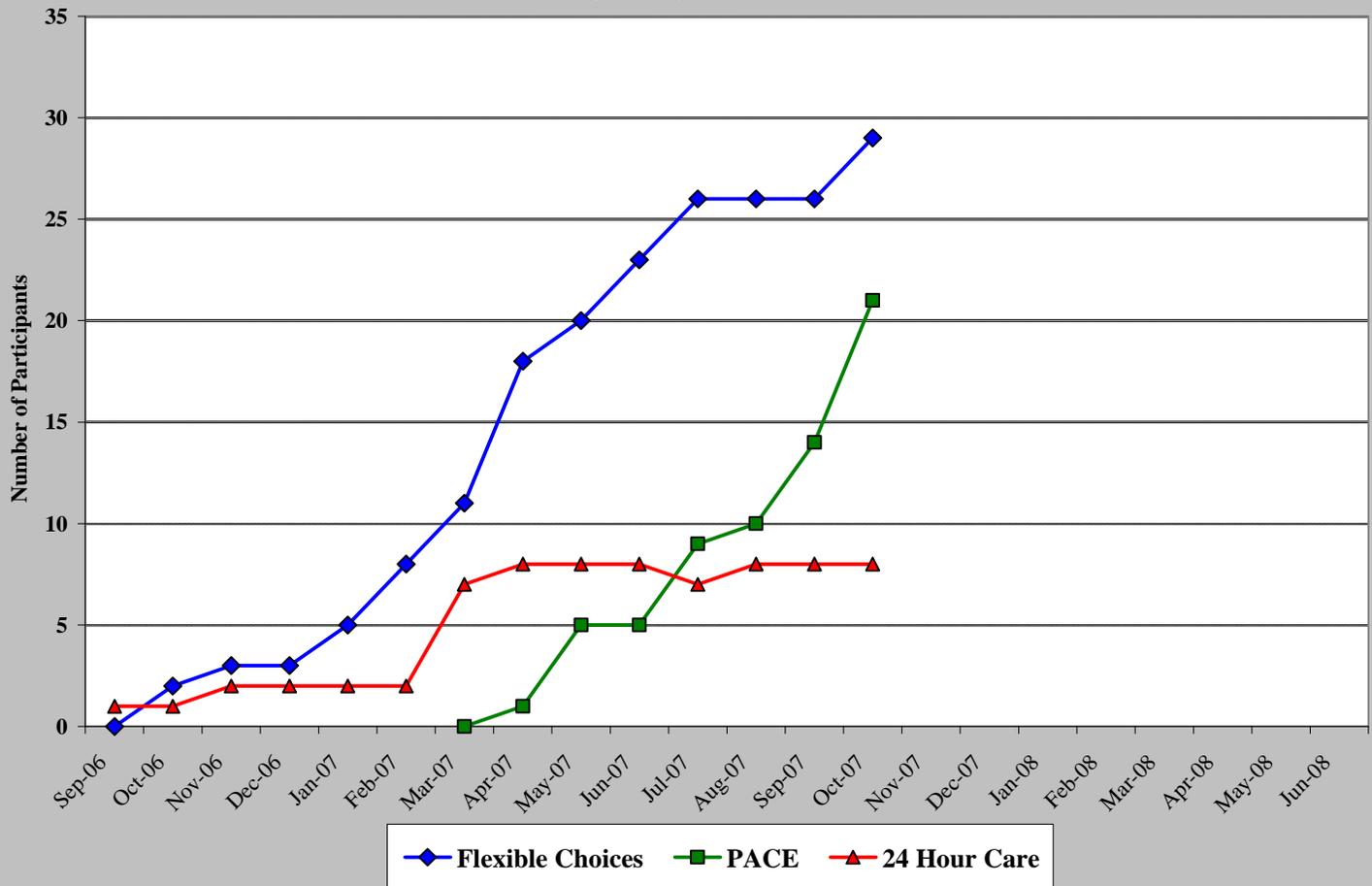


Data source: Adult Day provider reports

This graph shows the hours of services reported by all Vermont adult day service providers in sfy2007, including Choices for Care and all other types. The data suggest that the volume of services provided to the High/Highest Needs Group increased during the year. However, it appears that the total volume of services, including all types, decreased slightly. The provider reports also suggest that the number of hours of service may vary significantly from month to month.

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.

These represent substantially different service models, which tend to draw people with somewhat different expectations. Beyond the core difference in service delivery models, specific policy decisions (e.g. the funds made available to participants in Flexible Choices) may create relative incentives or disincentives for participants, and are likely to affect their choices.

In May 2007, Choices for Care also implemented a policy allowing spouses to be paid to provide personal care. Standard Medicaid laws and regulations prohibit payment to spouses (except under extraordinarily unique circumstances). This is allowed under an 1115 Waiver, and was developed as a new service option. Several factors (including restrictions on household income and the presence of a spouse who is able and available to provide care) can be expected to limit the number of people who use this service option. Unfortunately, no method currently exists to track the number of spouses who are paid to provide care.