



# **Choices for Care**

## **Quarterly Data Report**

### **October 2008**

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

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

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

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

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

**CONTENTS**

*page*

**Medicaid Long Term Care History..... 2**

**Applications..... 4**

**Waiting Lists..... 7**

**Enrollment and Service Data..... 13**

**Data by County.....17**

**Selected Data on Services, Funding and Participants.....38**

**Note:**

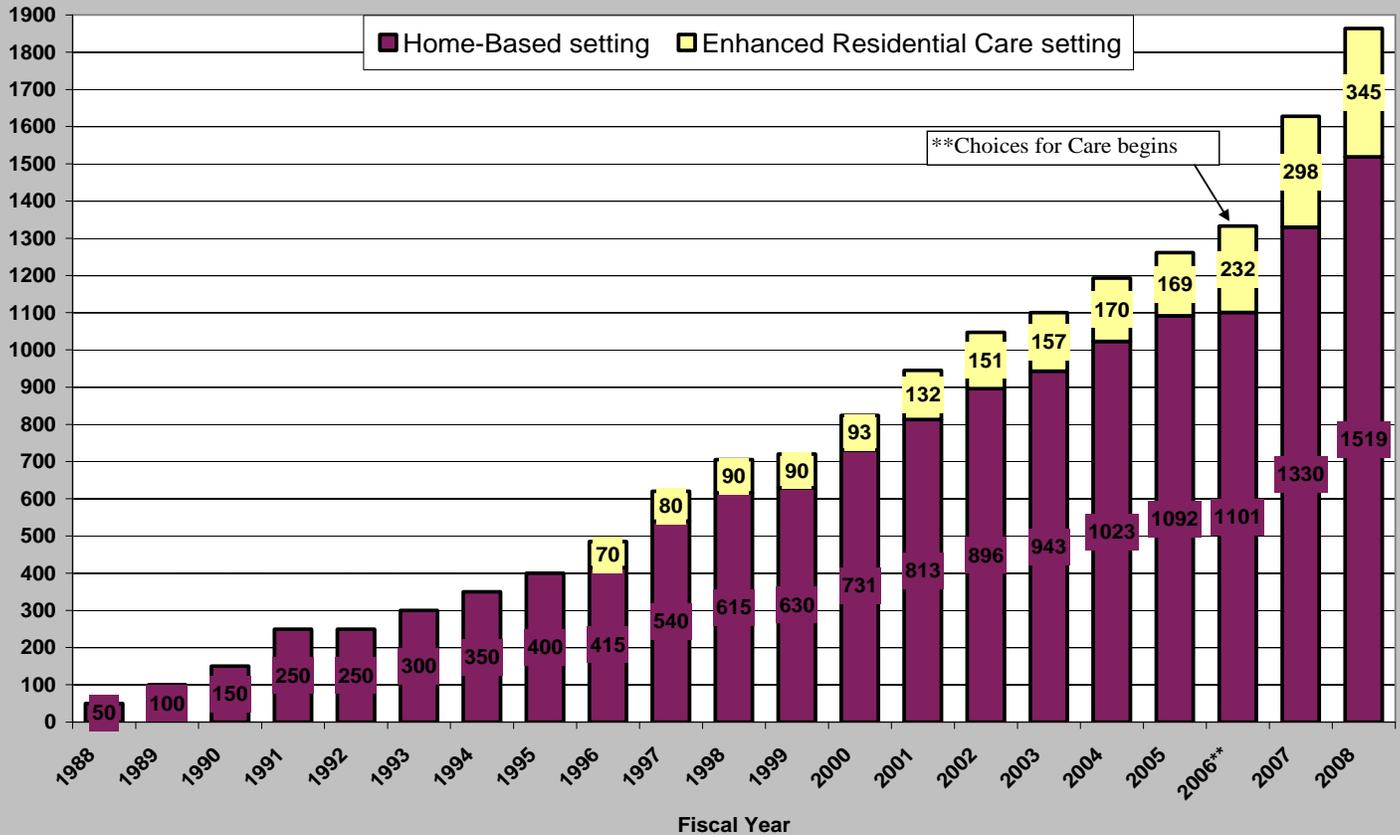
Vermont tracks a variety of process and reviews outcomes in a variety of areas in order to manage the Choices for Care Waiver. These include, but are not limited to:

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

Because multiple data sources are used for these purposes, sources may not be integrated or use the same methodologies for entry and extracts. For example, clinical eligibility determinations are tracked in one data base while financial eligibility determinations are tracked in another. The clinical data base may indicate an approval while the financial data is still pending or determined ineligible or vice versa. Due to the different methodologies and purposes, please note that information reported on the CMS64 reports does not match information from other data sources or program reports.

## Numbers of People Served in Aged/Disabled Medicaid Waivers Maximum Point-in-Time by Year, sfy1988-sfy2008

*(does not include moderate needs group)*



Data source: DAIL/DDAS databases

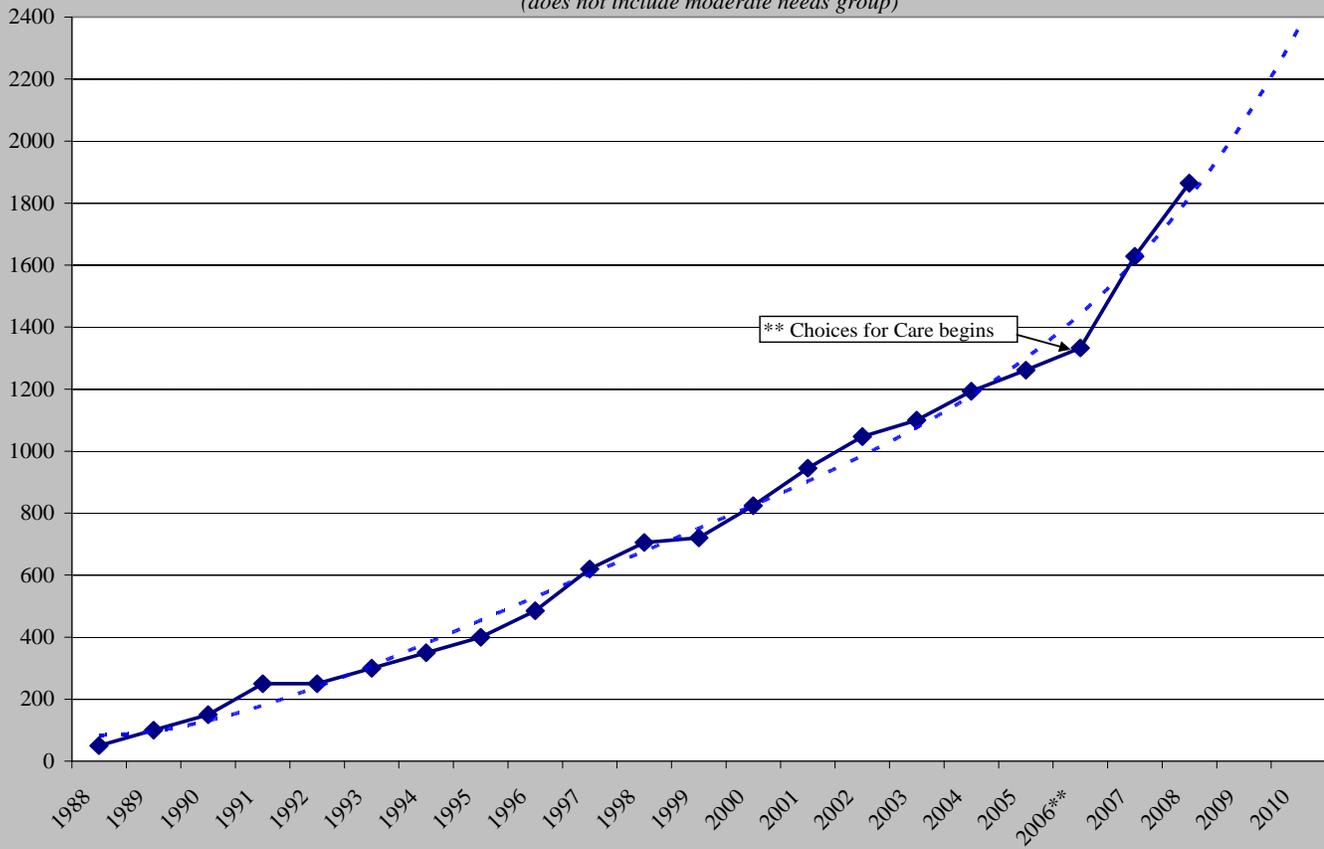
This graph illustrates the growth in home and community based services in Vermont since SFY1988.

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

In SFY2008, the number of people enrolled in alternative settings increased by nearly 240, following an increase of nearly 300 in SFY2007. The increase in the number of people served is significantly higher under Choices for Care, with annual increases approaching 20%.

## Numbers of People Served in Aging/Disabled Medicaid Waivers Maximum Point-in-Time by Year, sfy1988-sfy2008

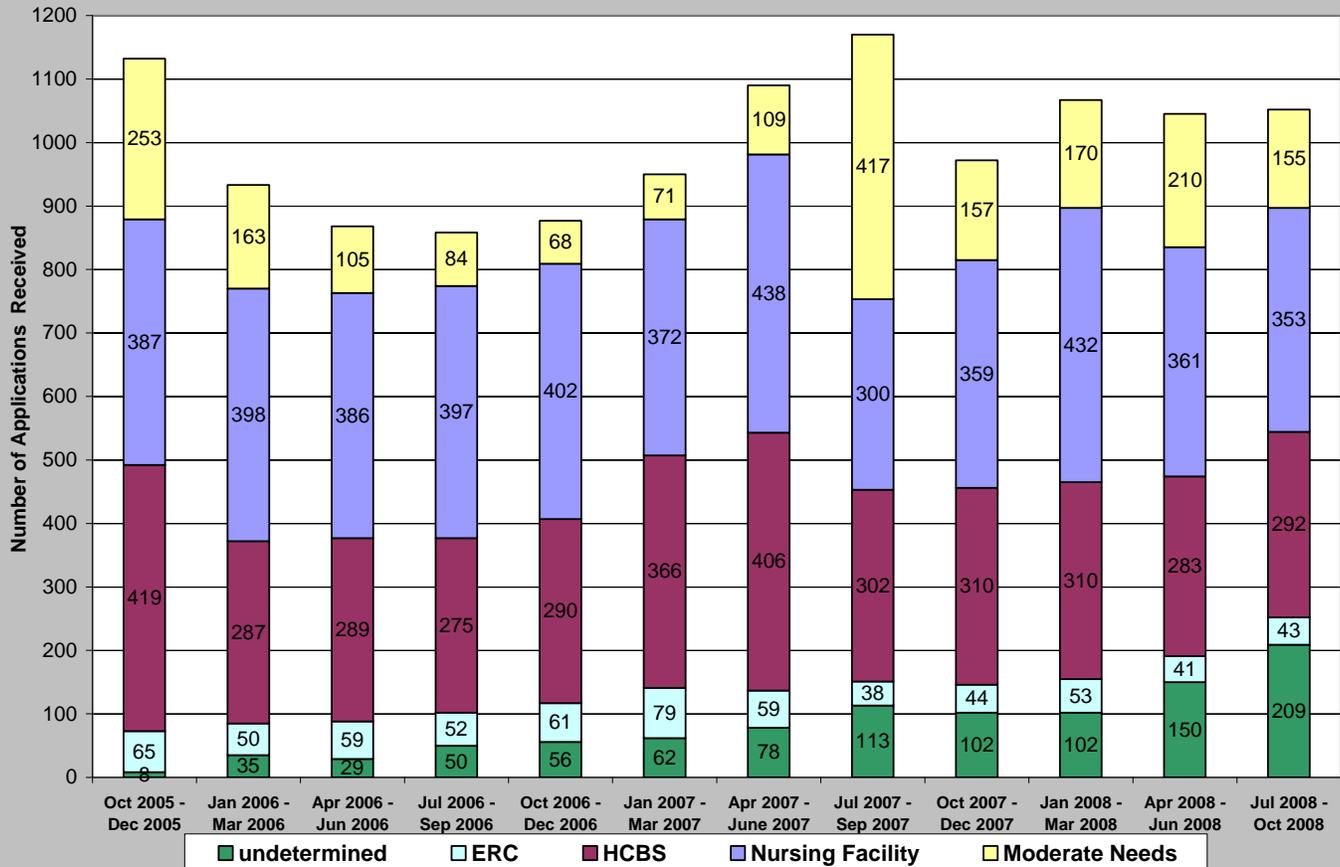
*(does not include moderate needs group)*



Data source: DAIL/DDAS databases

This graph combines HCBS and ERC enrollment, and projects enrollment trends through SFY2011. Enrollment in these alternative settings grew more quickly following the implementation of Choices for Care (in SFY2006) than at any other time in the past. The trend line suggests that enrollment in alternative settings will continue to increase.

**Choices for Care: Applications Received by Service Program  
October 1, 2005 through October 1, 2008**

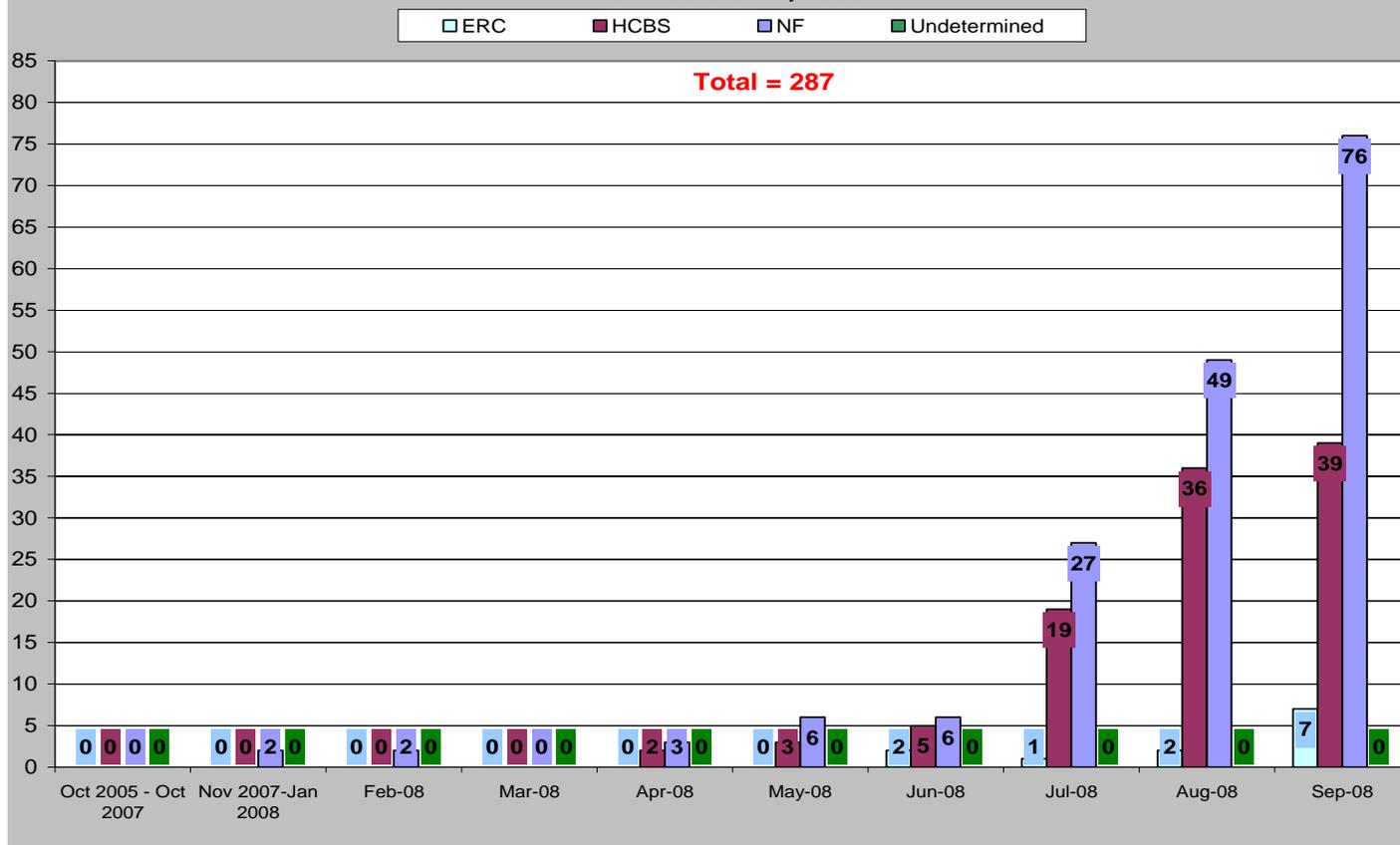


Data source: DAIL/DDAS SAMS database.

The number of applications has increased in the past two years, partly due to increased funding for the Moderate Needs Group. The average number of applications received each month by setting, by fiscal year:

Setting	SFY2006	SFY2007	SFY2008
undetermined	6	39	51
ERC	15	15	15
HCBS	83	100	98
Nursing Facility	98	121	127
Moderate Needs Group	43	80	59
<b>TOTAL</b>	<b>244</b>	<b>355</b>	<b>352</b>

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



Data source: DAIL/DDAS SAMS database.

One of the goals of Choices for Care is to help Vermonters access long term care services when they need them. An indicator of success is the time required to process individual applications.

This graph illustrates the length of time required from the date of the clinical eligibility decision to the LTC Medicaid financial eligibility decision. Over time, this number of applications 'pending Medicaid' had grown to more than 400. In recent months, this number has steadily decreased to less than 300, indicating progress.

In May 2008 the independent evaluators for the Vermont Aging and Disability Resource Centers project (Flint Springs Associates) examined sample baseline data to determine how long the Choices for Care clinical and financial eligibility determination processes take. On average:

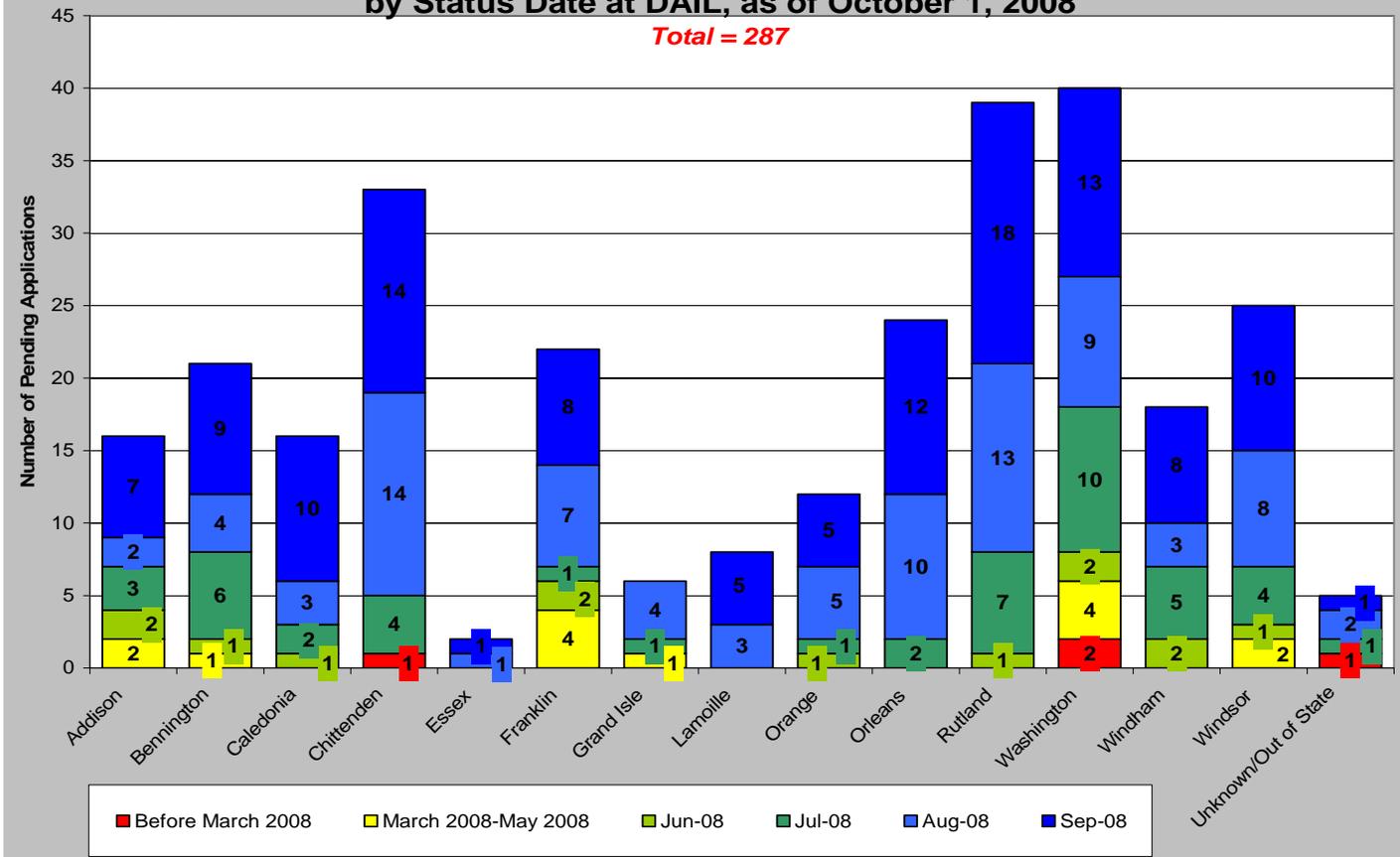
1. DAIL clinical assessments were conducted 10 days from the date that DAIL staff received an application. More than 75% of assessments were conducted within two weeks.
2. DCF financial eligibility determinations were made 66 days (about two months) after certification of clinical eligibility.
3. Both clinical and financial eligibility determinations were complete 106 days (3.5 months) after the date that the individual signed the CFC application.

Current SAMS data suggests shorter waiting periods. Based on the date of the DAIL clinical eligibility decision, people had been waiting for DCF financial eligibility decisions:

<b>Length of wait</b>	<b># people</b>	<b>% of people</b>
< 30 days	123	43%
31-60 days	77	30%
61-90 days	45	16%
> 90 days	27	11%

From the date of the DAIL clinical eligibility decision, the average number of days that people had been waiting for DCF financial eligibility decisions was 36 days. From the date that applications were received by DAIL, the average number of days that people had been waiting for DCF financial eligibility decisions was 48 days.

## Choices for Care: Pending Medicaid Applications by County by Status Date at DAIL, as of October 1, 2008

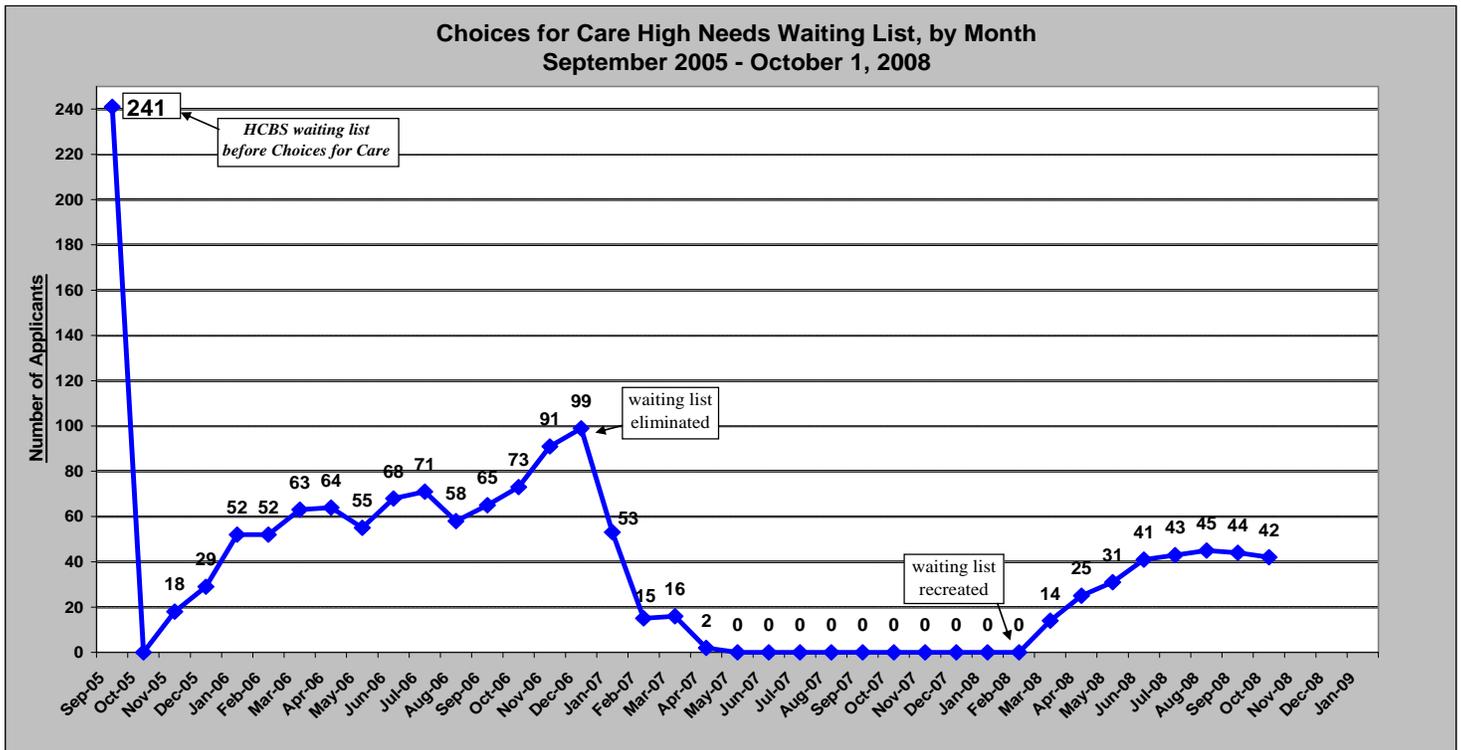


Data source: DAIL/DDAS SAMS database

The number of “old” pending applications can be used as an indicator of success in ensuring timely access to services. This graph provides an indicator of DAIL and DCF workload and performance within each county. Addison and Franklin counties had relatively high percentages of applications pending more than 90 days.

These findings suggest that timely access remains a problem for some applicants. Causes of delays in Medicaid financial eligibility decisions include:

1. Long-term care Medicaid applications are never submitted.
2. Long-term care Medicaid applications are delayed or incomplete.
3. Some applicants must spend or otherwise dispose of their excess resources to meet LTC Medicaid financial eligibility criteria.
4. Some applications lead to complicated asset searches and/or legal review by the Department for Children and Families (DCF).
5. Some applicants under the age of 60 (those not already eligible for SSI) are required to undergo a Disability Determination process, which routinely requires a number of months.



Data source: DAIL/DDAS SAMS database.

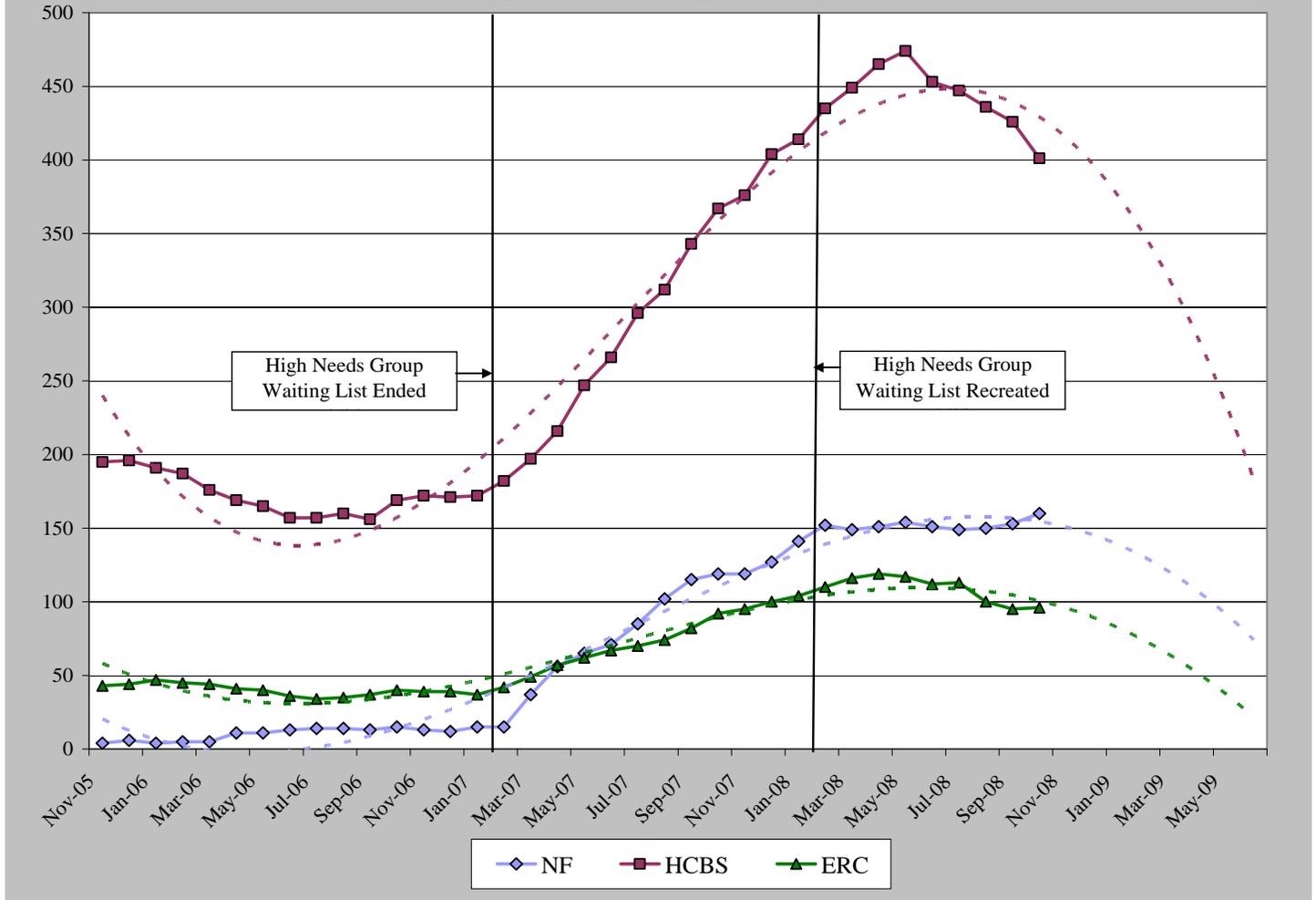
Another indicator of access to home and community based services is the number of people on waiting lists. Prior to Choices for Care, many applicants for HCBS and ERC were placed on waiting lists. The total number of people on waiting lists fell when Choices for Care was implemented in October 2005, when all applicants who meet Highest Needs Group eligibility criteria became entitled to the service of their choice.

The High Needs Group was created as a financial ‘safety valve’ in the Choices for Care expanded entitlement to HCBS, allowing DAIL to create a waiting list when expenditure projections exceed the budget. Note that the Choices for Care waiting list is unique in that it applies to people applying for all settings, including nursing homes. In other states, waiting lists are imposed for HCBS but not for nursing home services.

In October 2005, all applicants who met the High Needs Group eligibility criteria were placed on a waiting list. The number of people on this waiting list slowly increased over time. Based on the availability of funds, small numbers of people from the waiting list were enrolled in Choices for Care during July 2006 and December 2006. In January 2007, expenditure trends allowed all High Needs Group applicants to be enrolled, and the waiting list fell to zero.

Due to financial pressures, the high needs group waiting list was recreated in February 2008. The current economic climate suggests that the waiting list will continue for the foreseeable future. Of the 42 people on the waiting list in October 2008, 37 people were waiting for services in the HCBS setting, 3 people were waiting for services in the ERC setting, 1 person was waiting for services in the NF setting, and 1 person was undetermined.

## Choices for Care: High Needs Group Enrollment, sfy2006-sfy2009



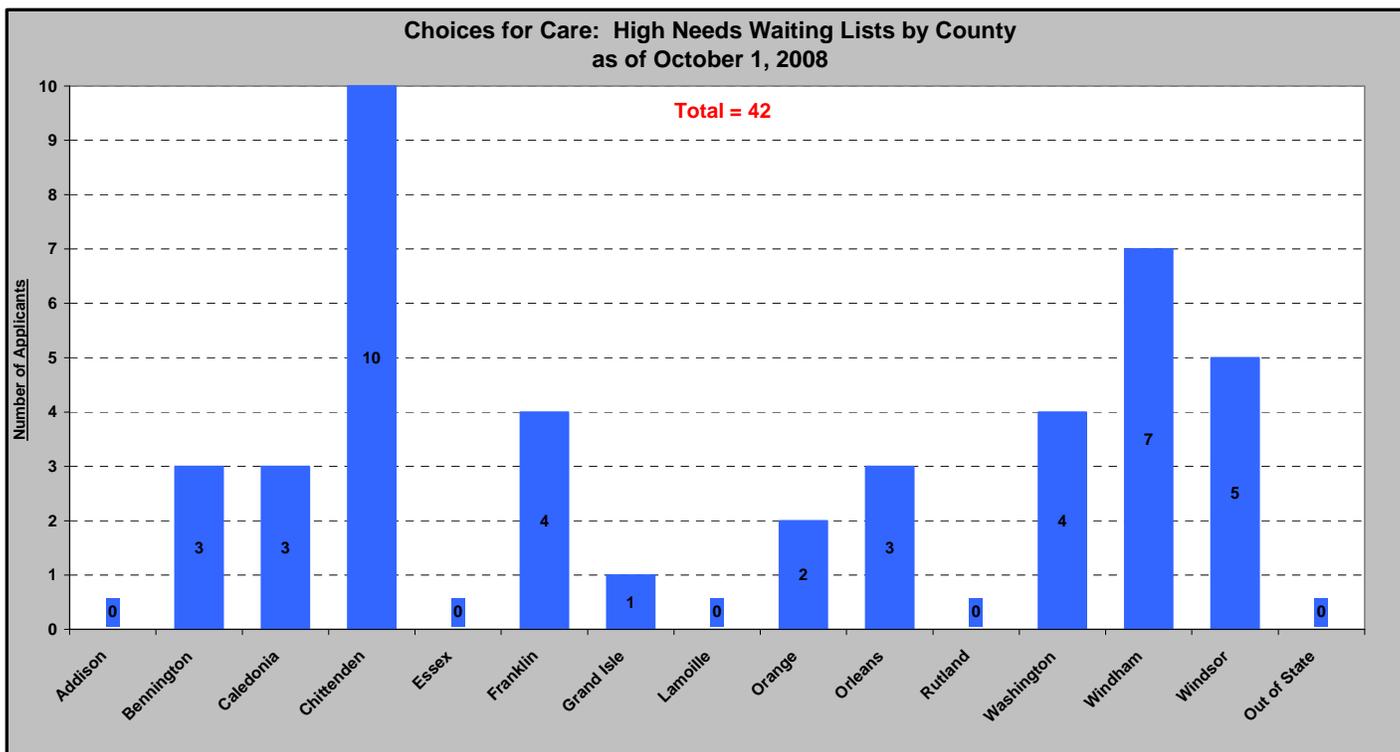
Data source: DAIL/DDAS SAMS database.

When the initial waiting list was lifted, High Needs Group enrollment increased by a total of 458 people, or nearly 200%. The largest increase occurred in the HCBS setting.

When the waiting list was recreated in February 2008, enrollment began to fall. Note that the decrease did not begin until several months had passed. The length of time required for all eligibility processes to be completed contributed to the delay in effect.

Recent data suggests:

1. The High Needs Group waiting list should reduce total enrollment and expenses in SFY2009. The waiting list does appear to serve as a financial ‘safety valve’, as intended by the original CFC design.
2. The largest drop in High Needs Group enrollment will occur in the HCBS setting.
3. Effects of changes in CFC eligibility or services are likely to be delayed for several months, and may not be substantial for six months or longer.



Data source: DAIL/DDAS SAMS database.

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

Choices for Care regulations allow people who meet High Needs Group eligibility criteria to be enrolled under ‘special circumstances’ to receive services. Most people who have been enrolled under special circumstances were served in the nursing home setting:

High Needs Special Circumstances- Service Setting	Before Feb. 2008 <i>by enrollment start date</i>		After Feb. 2008 <i>includes pending Medicaid</i>	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
HCBS	42	26%	10	20%
ERC	12	7%	4	8%
NF	108	67%	37	73%
Total	162	100%	51	100%

Because people’s needs change, it is important that we monitor the status and situation of people who are on the waiting list. This is one important role of case managers, who stay in touch with applicants and help people access other services. Case managers also help to identify people who should be served under special circumstances, or when someone’s needs have changed such that they meet the eligibility criteria for the highest needs group.

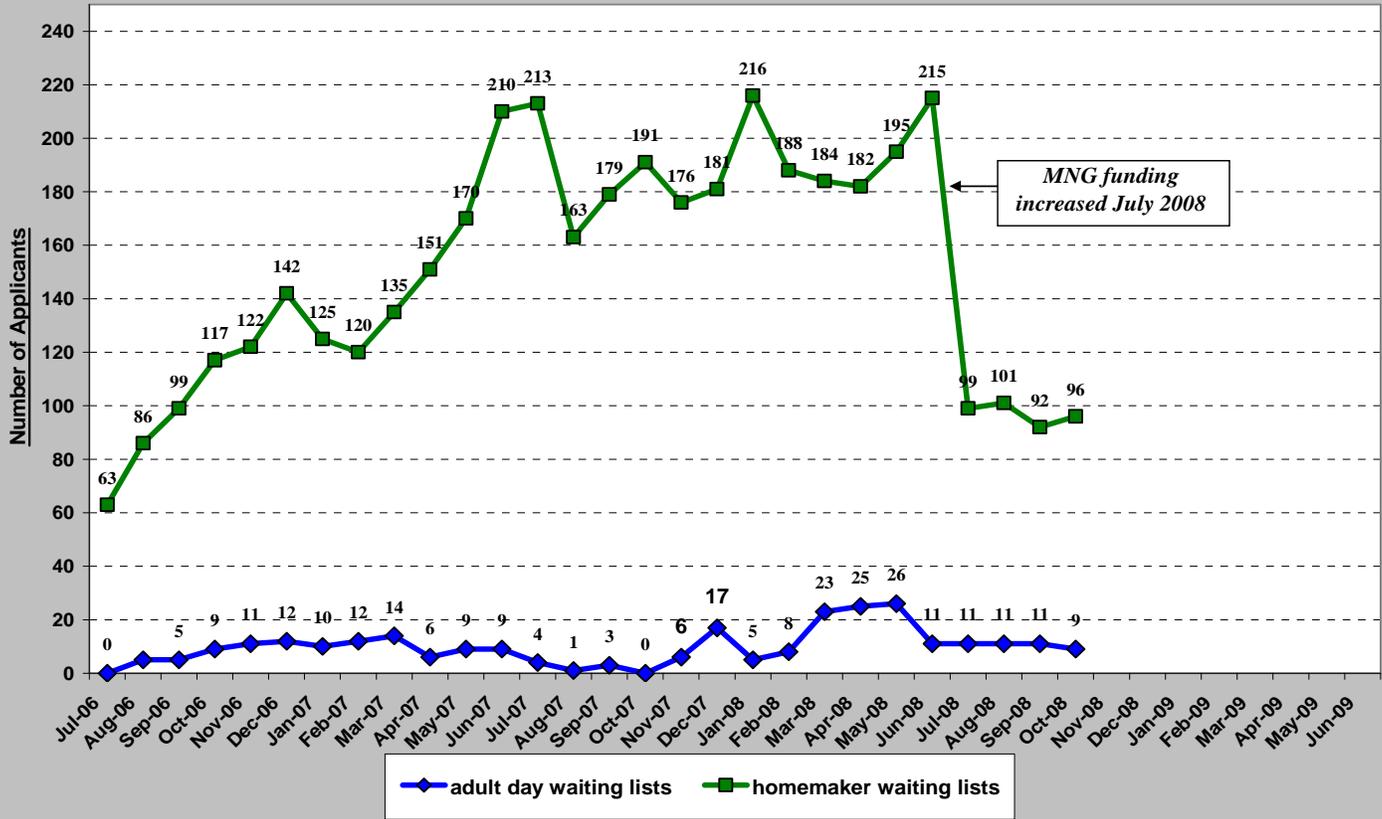
While case managers monitor the situations of the people who are on the waiting list, there are other aspects to the waiting list. During the period July 2007- January 2008, nearly 500

people were enrolled into the CFC high needs group. This represents about 70 people each month, or a total of 840 people annually.

Since the waiting list was created in February 2008, it has grown very slowly. Few people have been enrolled under special circumstances each month. Based on the previous trends, this seems to leave more than 50 people unaccounted for each month. What happened to the hundreds of people in the high needs group who we would have expected to apply, but did not? Several theories or explanations have emerged:

1. Some people rely on unpaid caregivers: family, friends, and neighbors. Across the United States, this is the most common solution. AARP estimates that unpaid family caregivers provide about 80 percent of the assistance provided to people who need help with daily activities. (<http://www.aarp.org/research/housing-mobility/caregiving/aresearch-import-779-FS91.html>)
2. Some people use alternative services: home health services, area agency on aging services, residential care homes, adult day services, etc..
3. Some people are served through the moderate needs group.
4. Some people simply 'make do', getting by with little or no assistance.

### Choices for Care: Moderate Needs Group Waiting Lists by Type of Service SFY2006 - SFY 2009



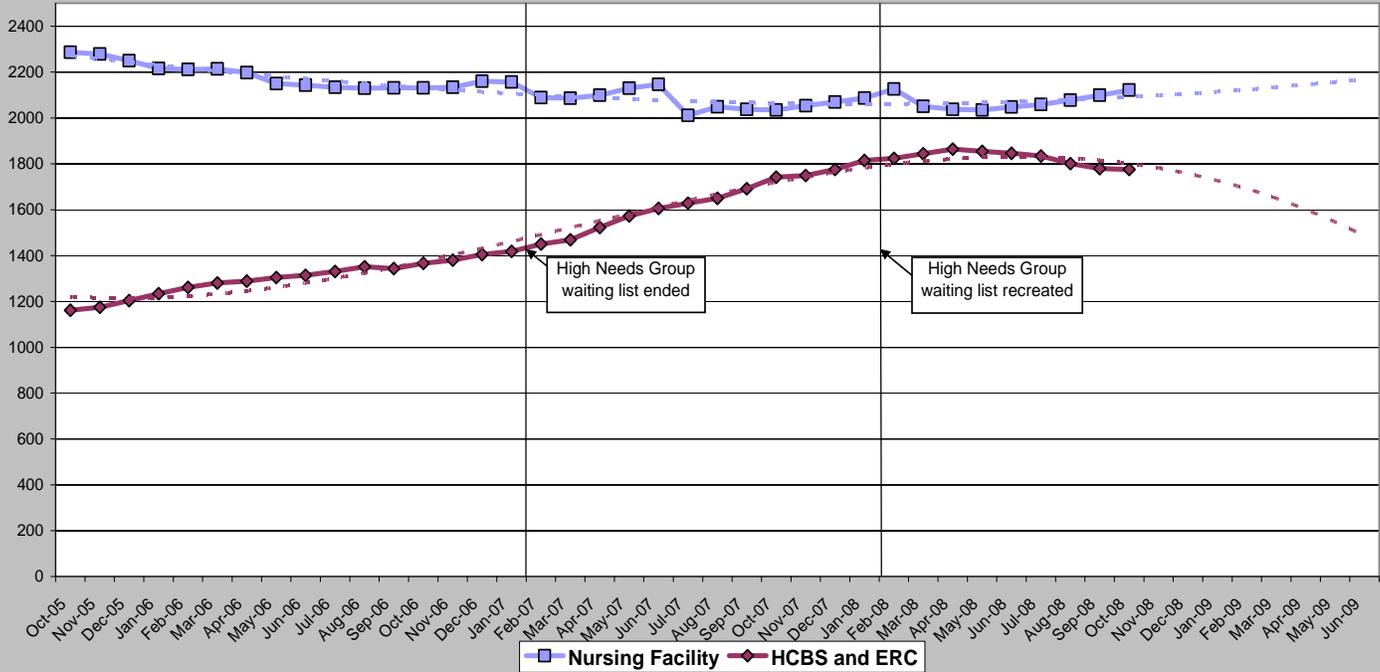
Data source: waiting list reports from home health agencies and adult day programs.

This graph shows the numbers of people placed on waiting lists for Moderate Needs Group services. The graph starts in July 2006, when providers began to submit monthly waiting list data to DAIL/DDAS.

The number of people waiting for Homemaker services increased steadily until June 2008, when additional funding was made available for Homemaker services. Of the thirteen Homemaker providers, six reported waiting lists in October 2008. The number of people on the Homemaker waiting lists ranged from 1 to 125. Some providers have reported that the costs of providing services are higher than the reimbursement rate, and that they limit the number of hours of service that they provide. Some providers have also reported challenges in recruiting and retaining adequate numbers of staff.

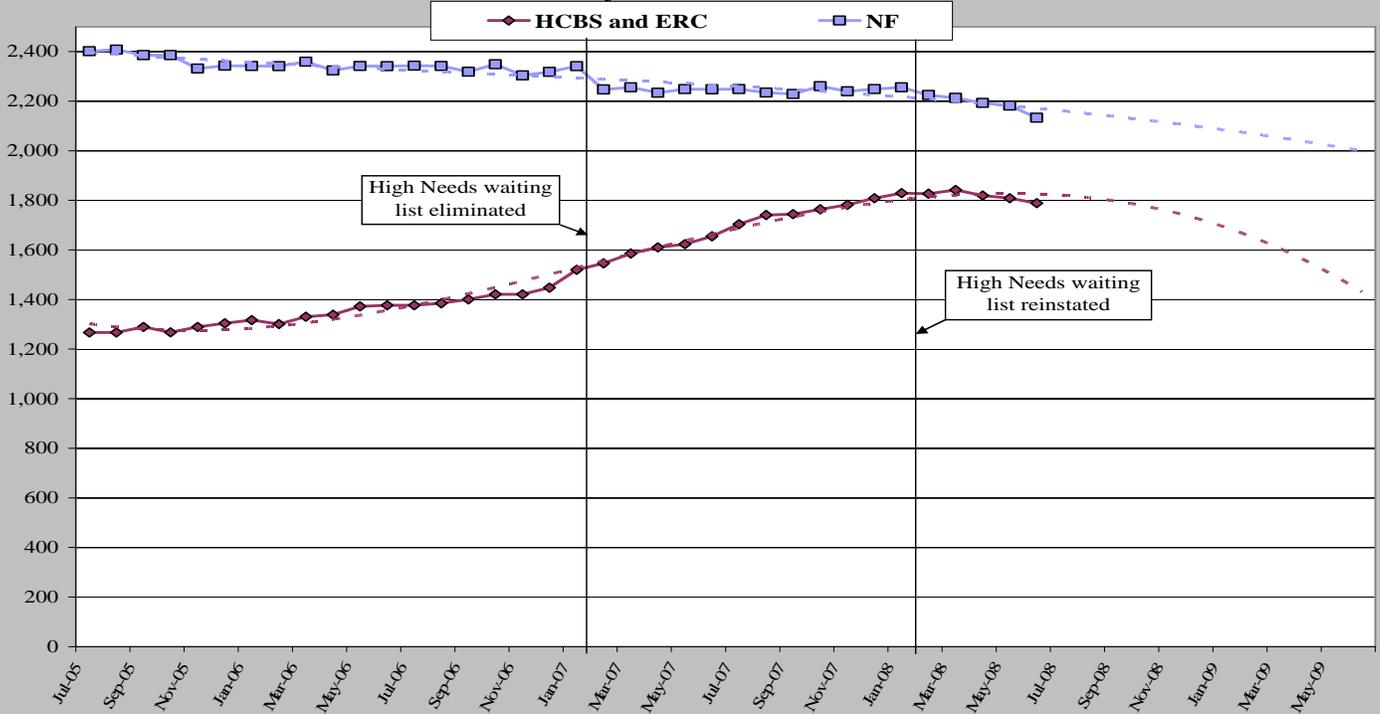
The number of people waiting for Adult Day services has varied overtime, but has never exceeded 26 people. Of the fourteen Adult Day providers, two reported waiting lists in October 2008. The number of people on the Adult Day waiting lists ranged from 1 to 8.

**Choices for Care: Total Number of Enrolled Participants**  
**October 2005 - October 2008**  
*(excluding Moderate Needs Group)*



Data source: DAIL/DDAS SAMS database.

**Use of Medicaid Long Term Care Services by Setting (excluding Moderate Needs Group)**  
**July 2005 - June 2009**



Data source: EDS paid Medicaid claims by date of service

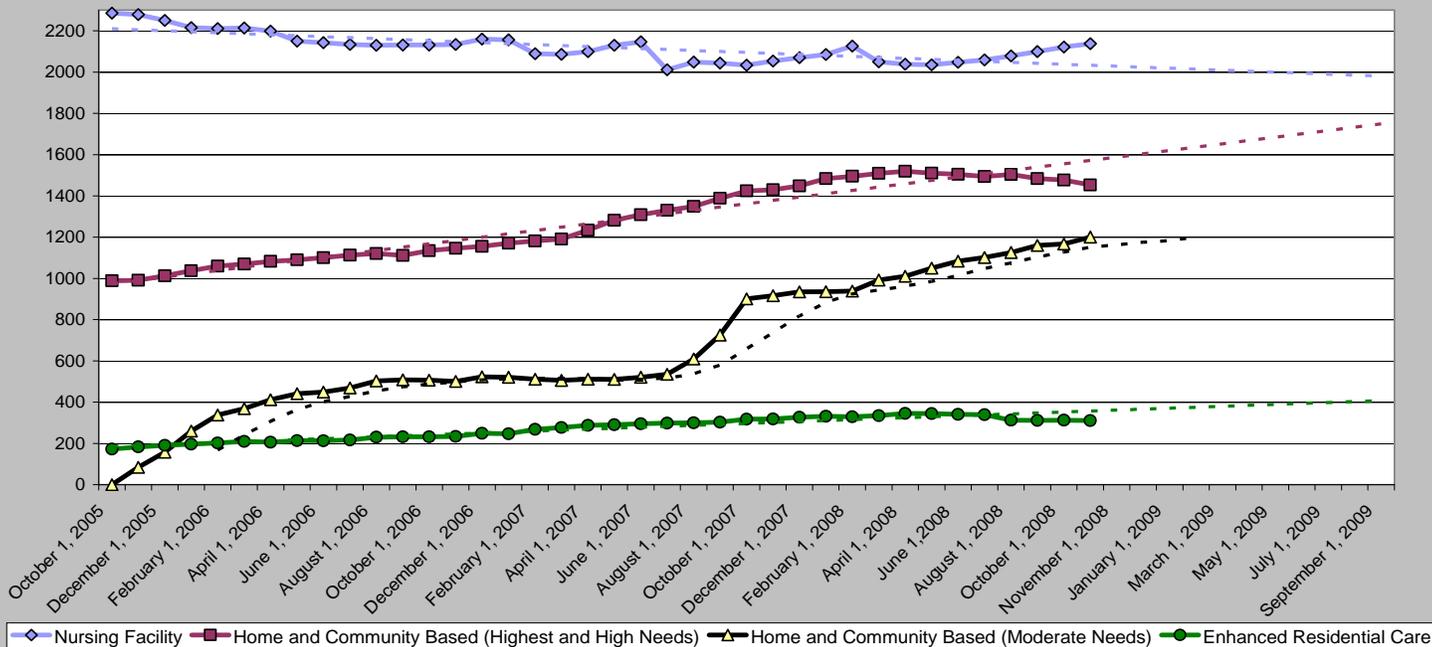
These show trends in enrollment of people in the Highest Needs Group and the High Needs Group (who all meet the 'traditional' nursing home clinical and functional eligibility criteria). The first graph is from SAMS enrollment data, showing point-in-time enrollment.

The second is from paid Medicaid claims, showing total unduplicated numbers of people served each month. Because of the different methodologies, the second graph shows larger numbers of people, as expected.

Taken together, the two data sources show:

- Nursing homes: a slow decrease in the number of people served through June 2008. After that date SAMS enrollment shows an increase, while paid Medicaid claims show a continued decrease. Given the discrepancy, it is not clear which trend has actually occurred in the past few months. This will become clearer in the next few months.
- Alternative settings: a slow, steady increase in the number of people served through April 2008. After that date both SAMS enrollment and paid Medicaid claims show a slow decrease – an effect of the High Needs Group waiting list.

**Choices for Care: Total Number of Enrolled Participants  
October 1, 2005 - October 1, 2008**



Data source: DAIL/DDAS SAMS database.

**Nursing homes:** the number of people enrolled in the nursing home setting decreased by about 150 between October 2005 and October 2008. This was associated with a decrease in Vermont instate nursing home capacity, totaling 131 beds:

Oct 2005	Newport	-10	Orleans
Jan 2006	Mt Ascutney	-8	Windsor
Sept 2006	Gifford	+10	Orange
Oct 2006	Burlington Health & Rehab	-42	Chittenden
Feb 2007	Morrisville	-90	Lamoille
Aug 2007	Wake Robin	+18	Chittenden
Jan 2008	Mt Ascutney	-15	Windsor
Jan 2008	Veterans Home	-7	Bennington
April 2008	Berlin	-11	Washington
April 2008	Rowan Court	-8	Washington
July 2008	Copley	+32	Lamoille

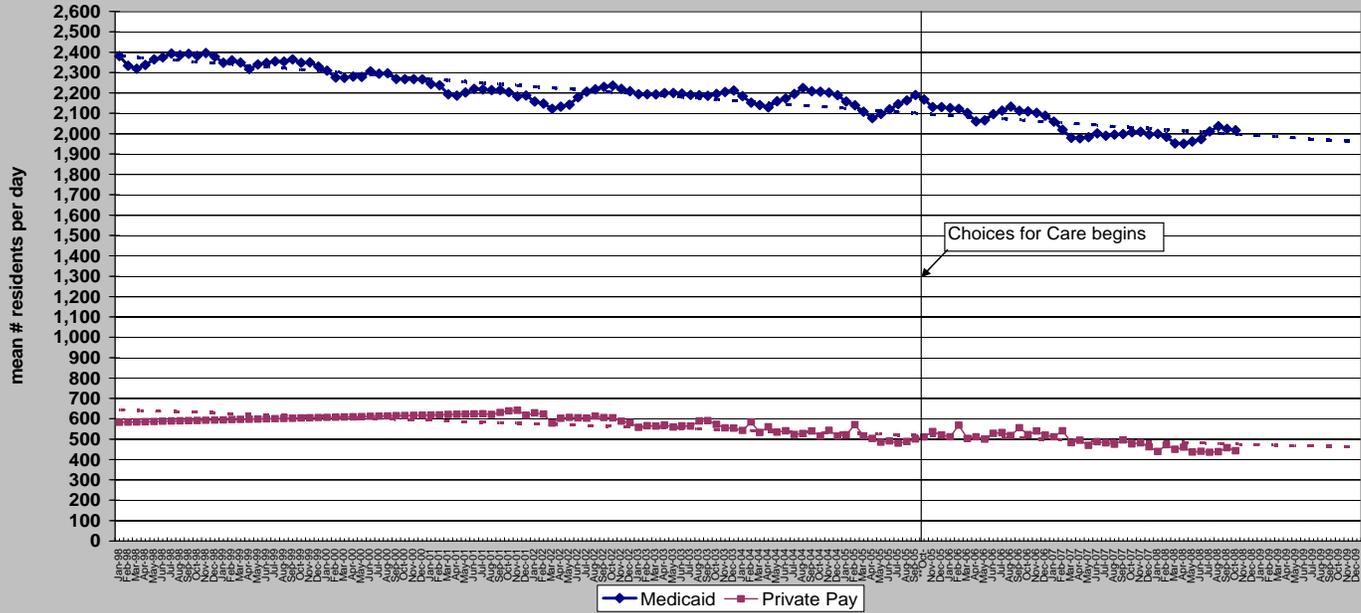
**Home and Community Based Services (Highest/High Needs Groups):** between October 2005 and October 2008, the number of people enrolled increased by more than 450. The number of people has slowly decreased in the past six months.

**Enhanced Residential Care:** between October 2005 and October 2008, the number of enrolled people increased by almost 150 people (nearly 100%). The number of people has slowly decreased in the past six months.

**HCBS Moderate Needs Group:** this ‘expansion’ group was created in October 2005, and by October 2008 had grown to 1200 people. Large increases in Moderate Needs Group enrollment in SFY2008 (nearly 600 people) were supported by a substantial increase in MNG Homemaker service funding.

### Vermont Nursing Home Bed Use: Medicaid and Private Pay Average Number of Residents per Day, July 1998 - October 2008

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

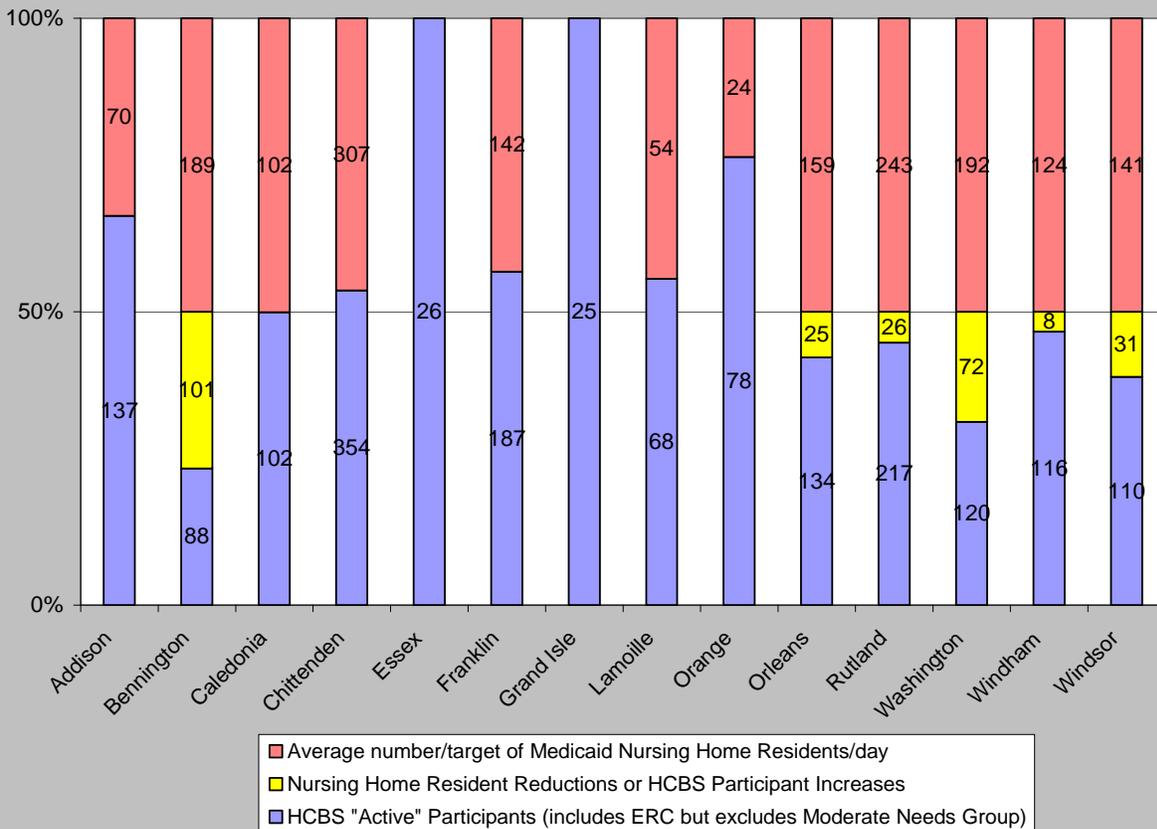


cfc 18

Data source: DRS, monthly provider reports

The number of people in Vermont nursing homes with Medicaid as primary payor has decreased by about 150 since October 2005 - from about 2,170 to about 2,020. The number of people who pay privately has also decreased, from about 510 people to about 440 people.

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



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

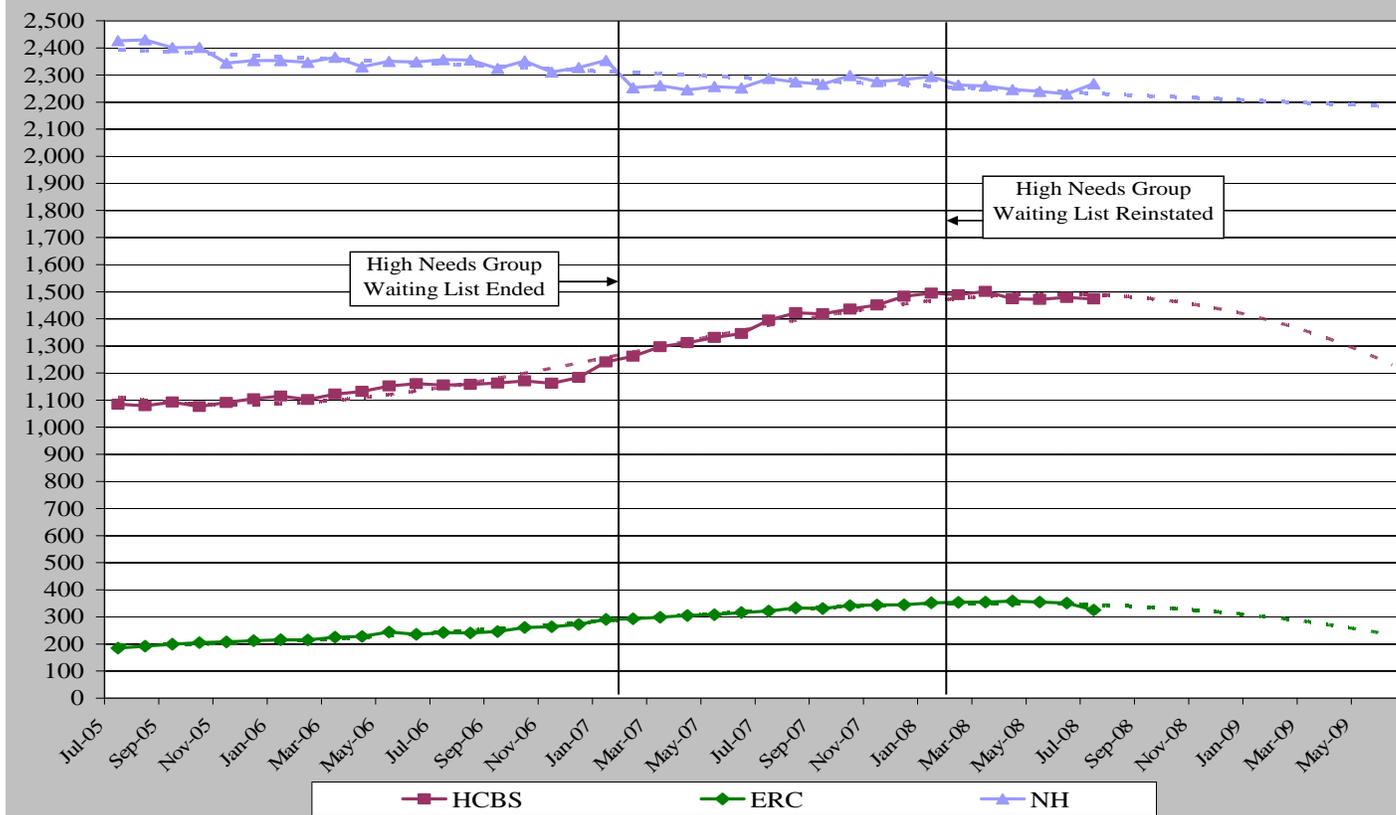
One of the expected outcomes of *Choices for Care* is that a higher percentage of people who use Medicaid-funded long term care will choose community settings, while a lower percentage will choose nursing homes. This graph illustrates the relative use of nursing homes and other settings in each county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

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

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

### Vermont: Choices for Care Participants by Setting, sfy2005 - sfy2009

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



Data source: EDS paid claims

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

1. Since the implementation of Choices for Care, decreasing use of nursing home services accompanied by increasing use of both Home and Community-Based Services and Enhanced Residential Care. This is the expected outcome of Choices for Care.
2. Since the reinstatement of the High Needs Group waiting list, modest decreases in the use of all service settings. This is the expected outcome of the waiting list.

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

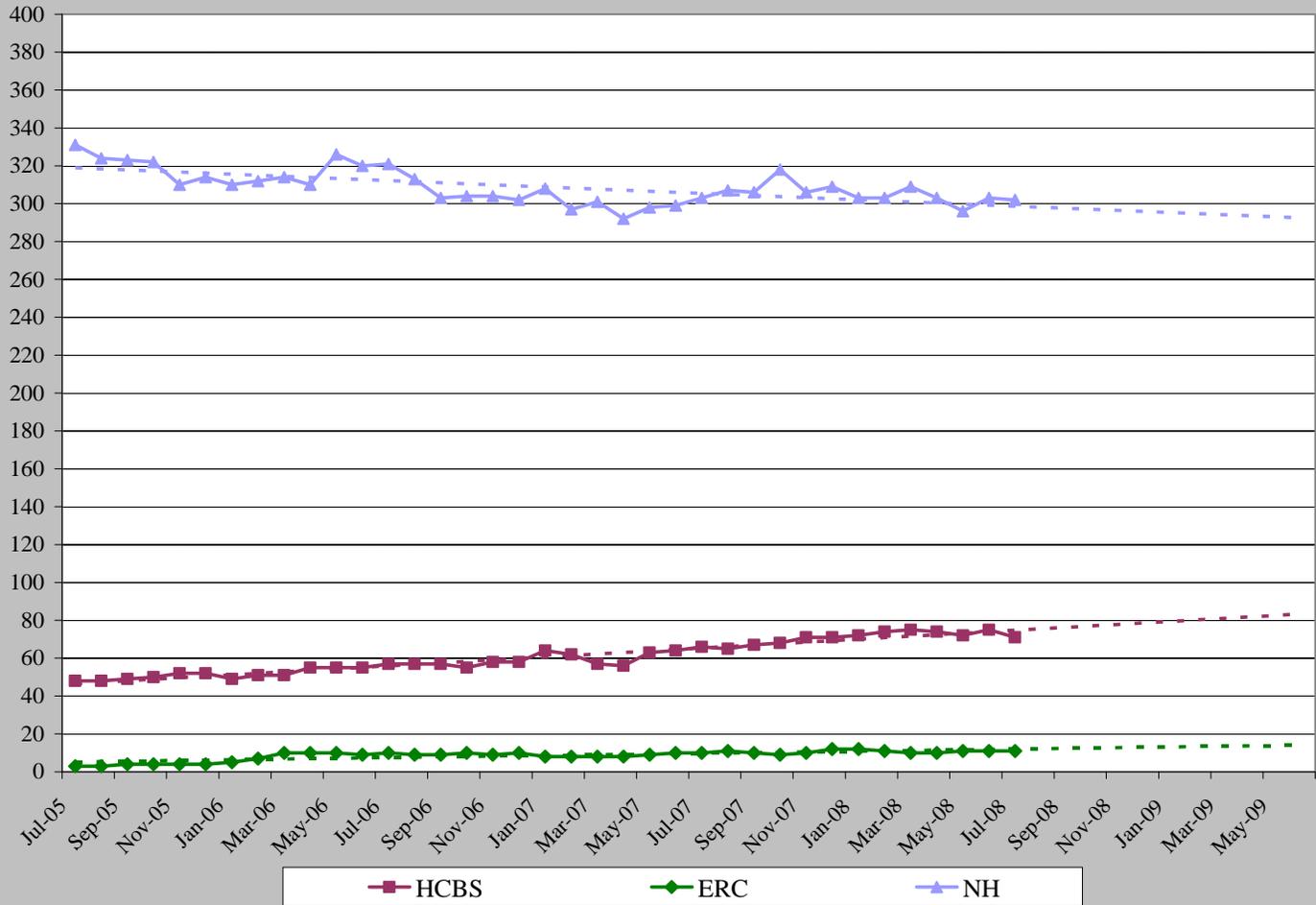
Large counties: Bennington, Chittenden, Rutland, Washington, Windsor

Medium counties: Franklin, Orleans, Windham

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

### Bennington County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

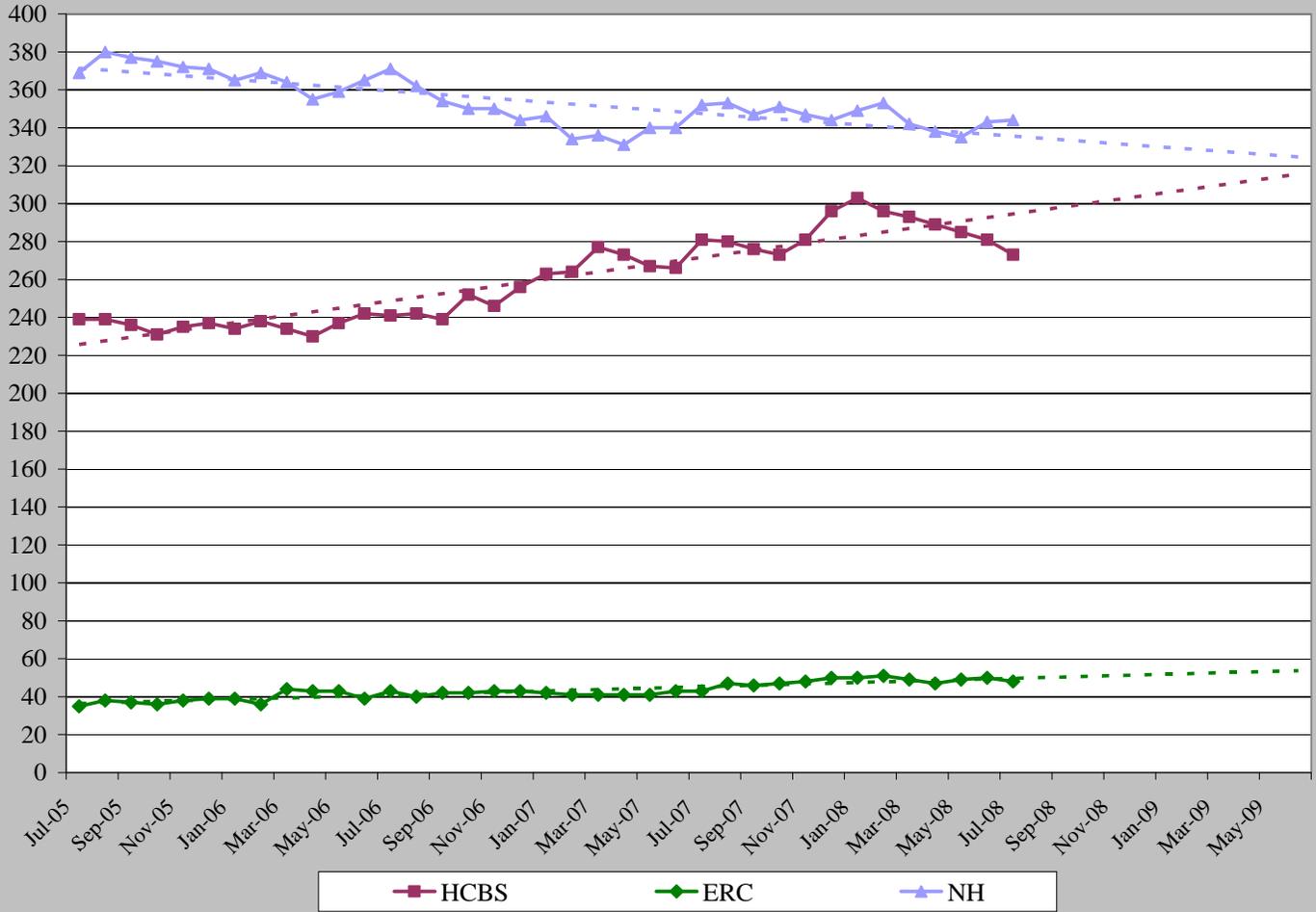


Data source: EDS paid claims

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

### Chittenden County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

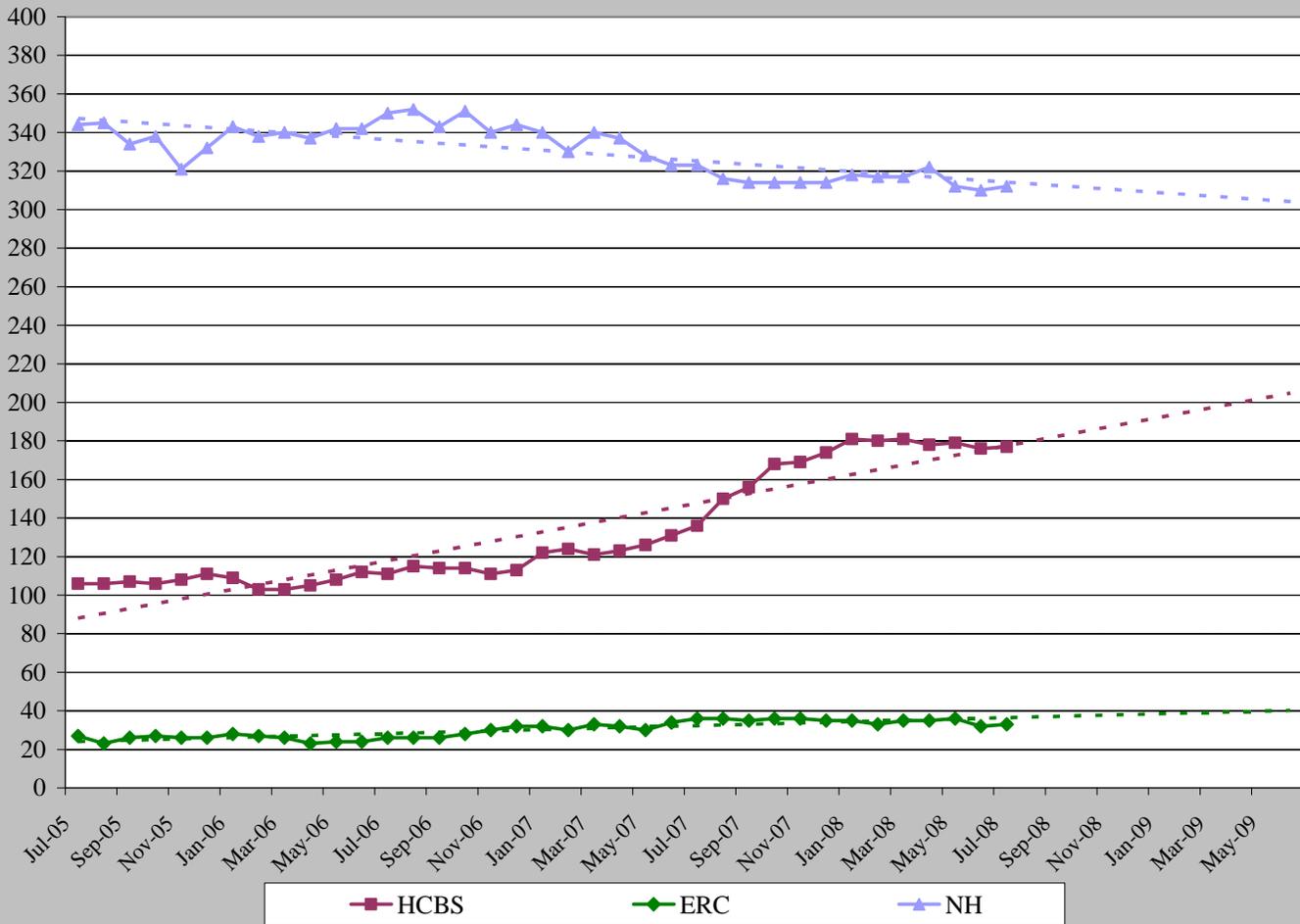


*Data source: EDS paid claims*

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

### Rutland County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

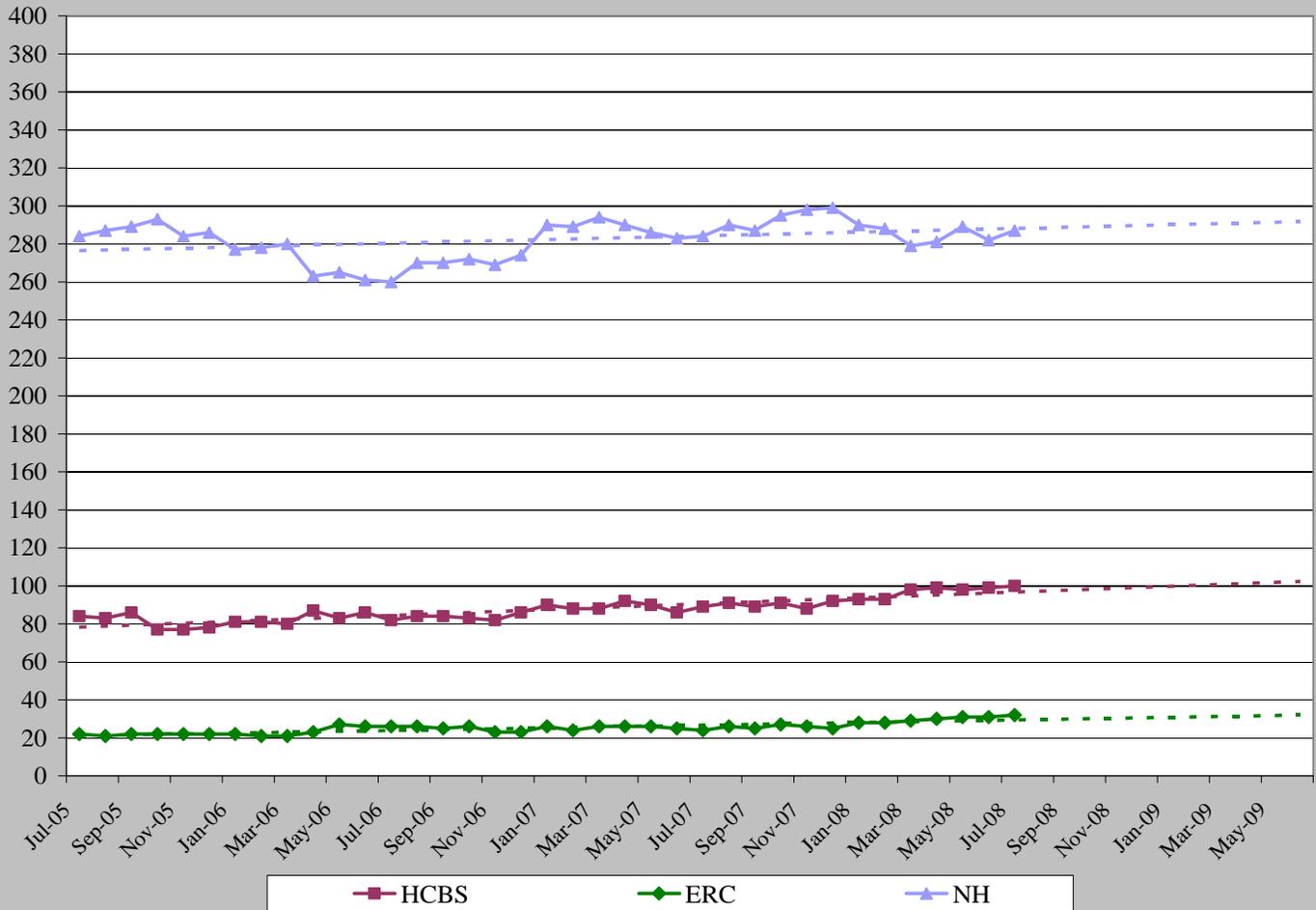


*Data source: EDS paid claims*

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

### Washington County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

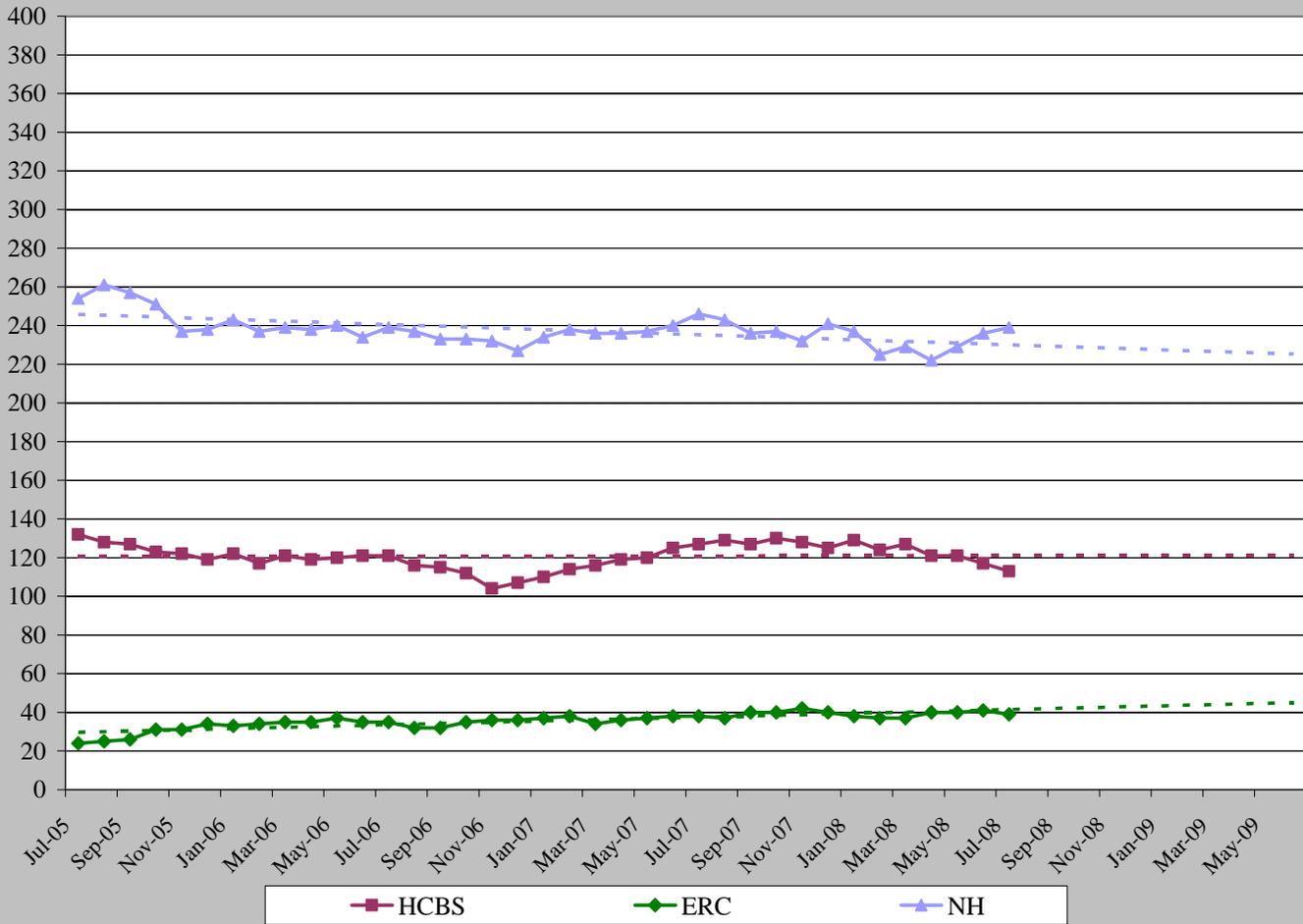


*Data source: EDS paid claims*

In Washington County, use of both HCBS and ERC has increased slowly since July 2005. The use of nursing homes slowly declined between July 2005 and August 2006, but has increased since then. It appears that the expected outcome of Choices for Care has not been realized in Washington County.

### Windsor County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

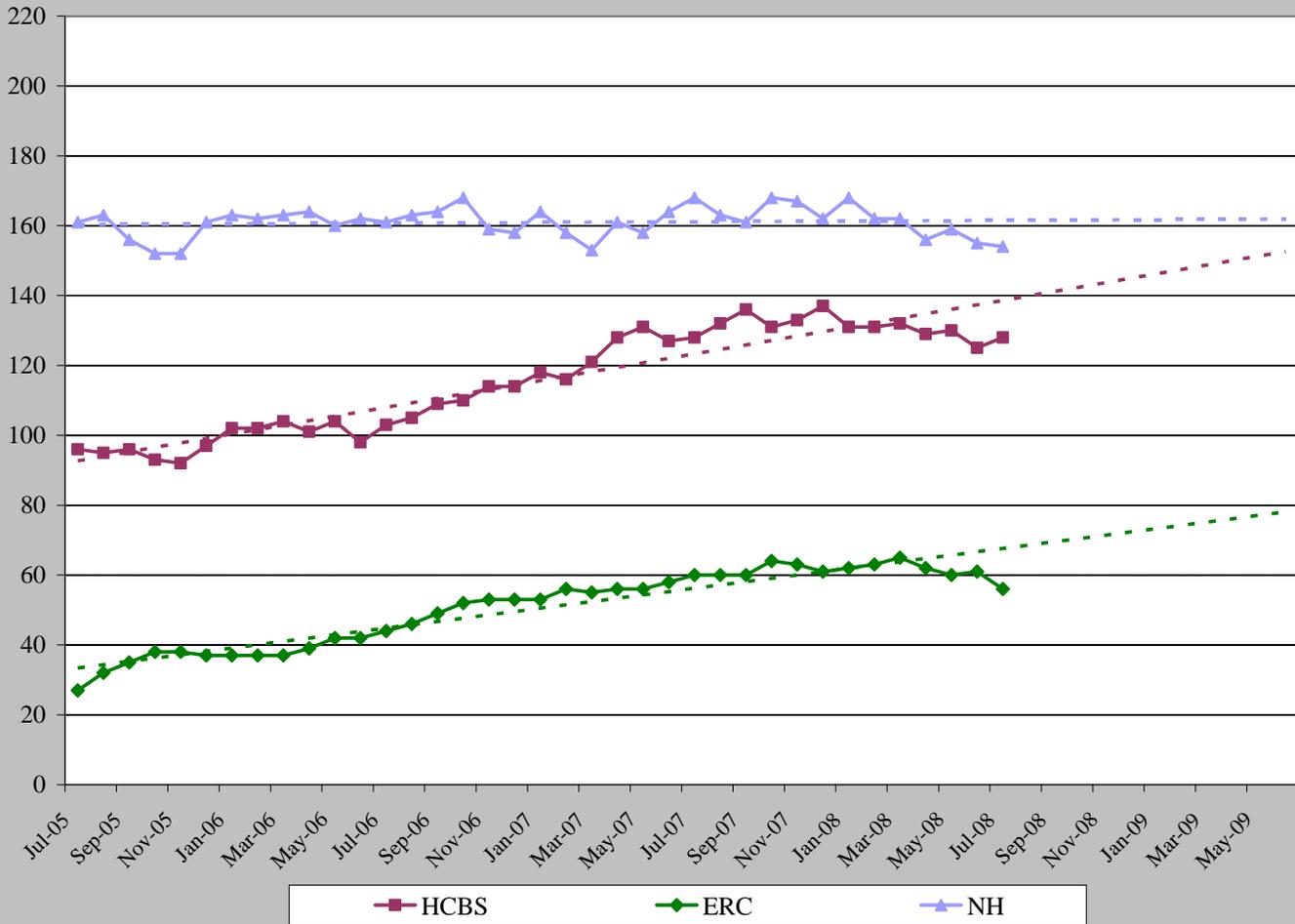


Data source: EDS paid claims

In Windsor County, use of ERC has increased since July 2005, while the use of HCBS is slightly lower than in July 2005. The use of nursing homes has decreased. While the decreased use of HCBS was not expected, the decreased use of nursing homes is the expected outcome of Choices for Care.

### Franklin County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

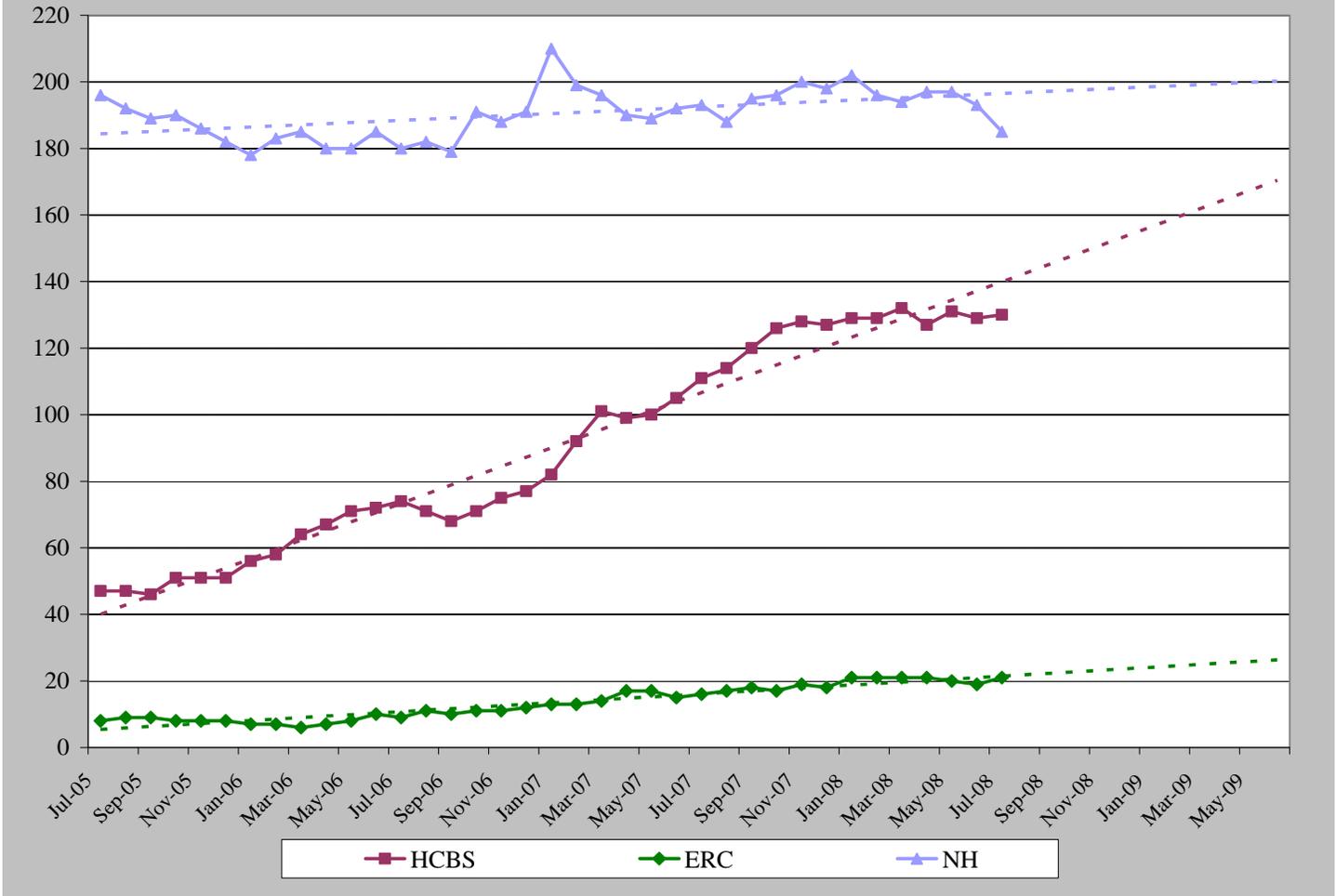


*Data source: EDS paid claims*

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

### Orleans County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

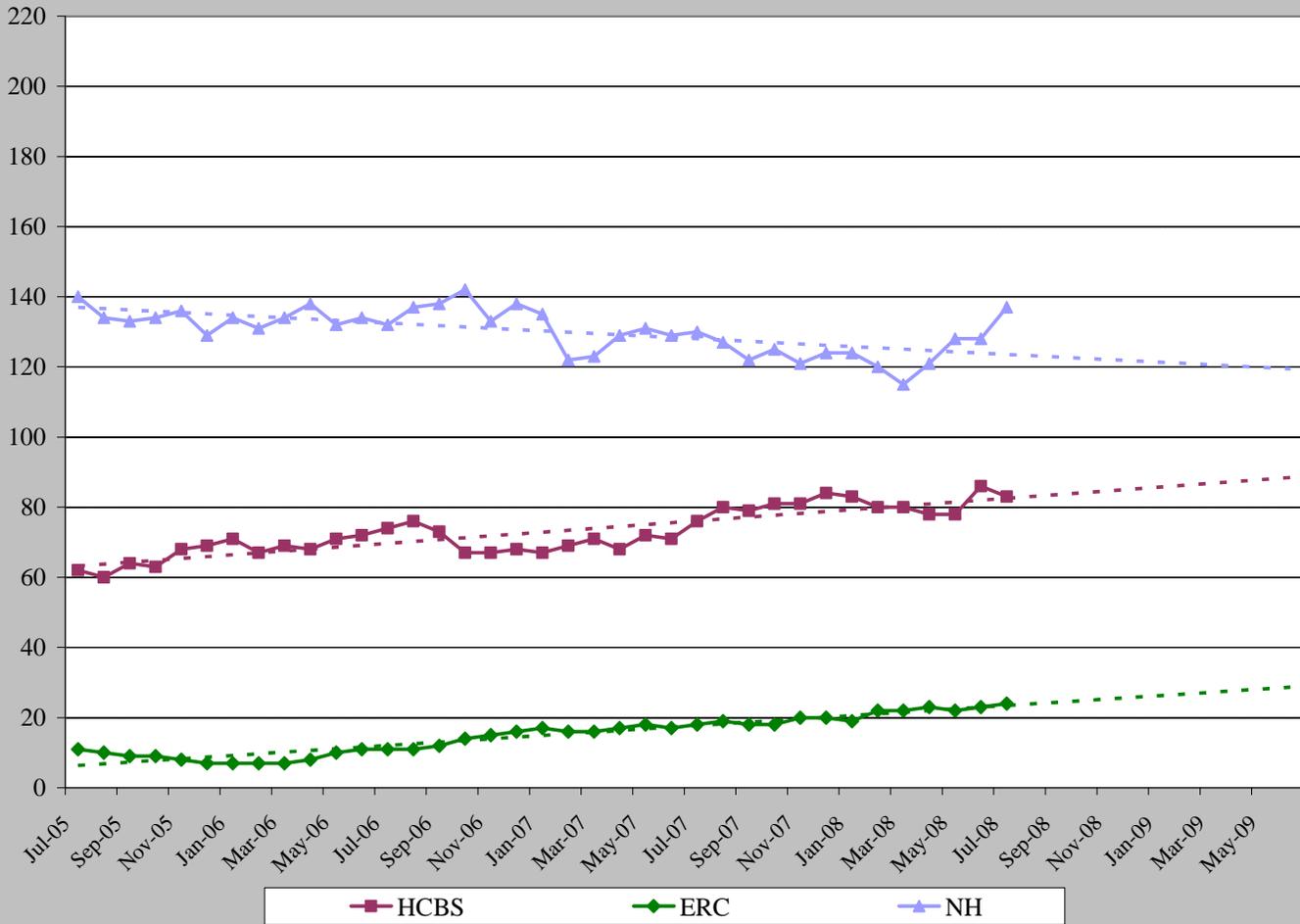


*Data source: EDS paid claims*

In Orleans County, use of HCBS has increased significantly since July 2005, while use of ERC has increased more slowly. However, the use of nursing homes has increased. It appears that the expected outcome of Choices for Care has not been realized in Orleans County.

### Windham County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

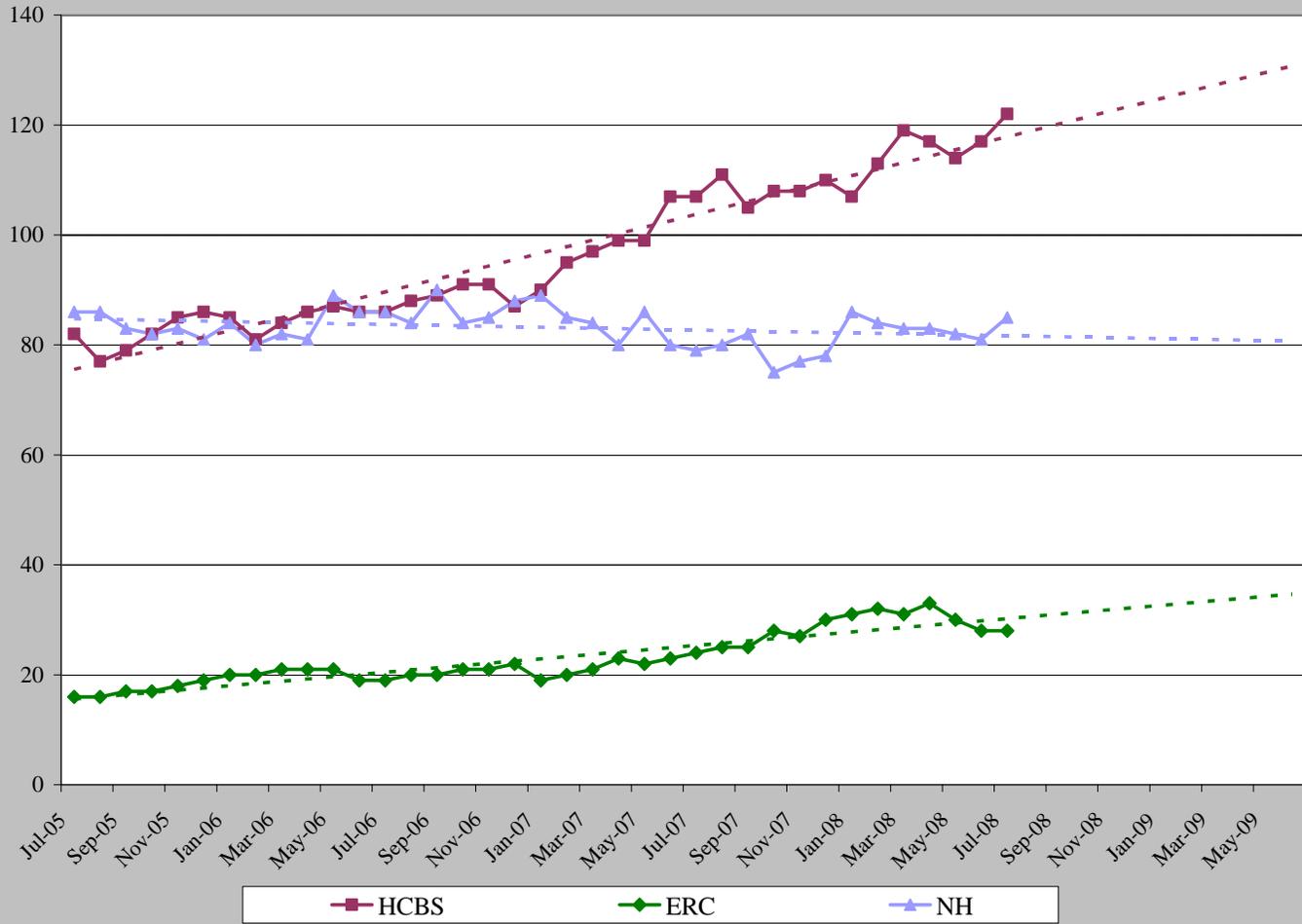


*Data source: EDS paid claims*

In Windham County, use of both HCBS and ERC has increased since July 2005. The use of nursing homes decreased, but has increased significantly in recent months. In spite of growth in the use of alternate settings, it appears that the expected outcome of Choices for Care has not been realized in Windham County.

### Addison County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

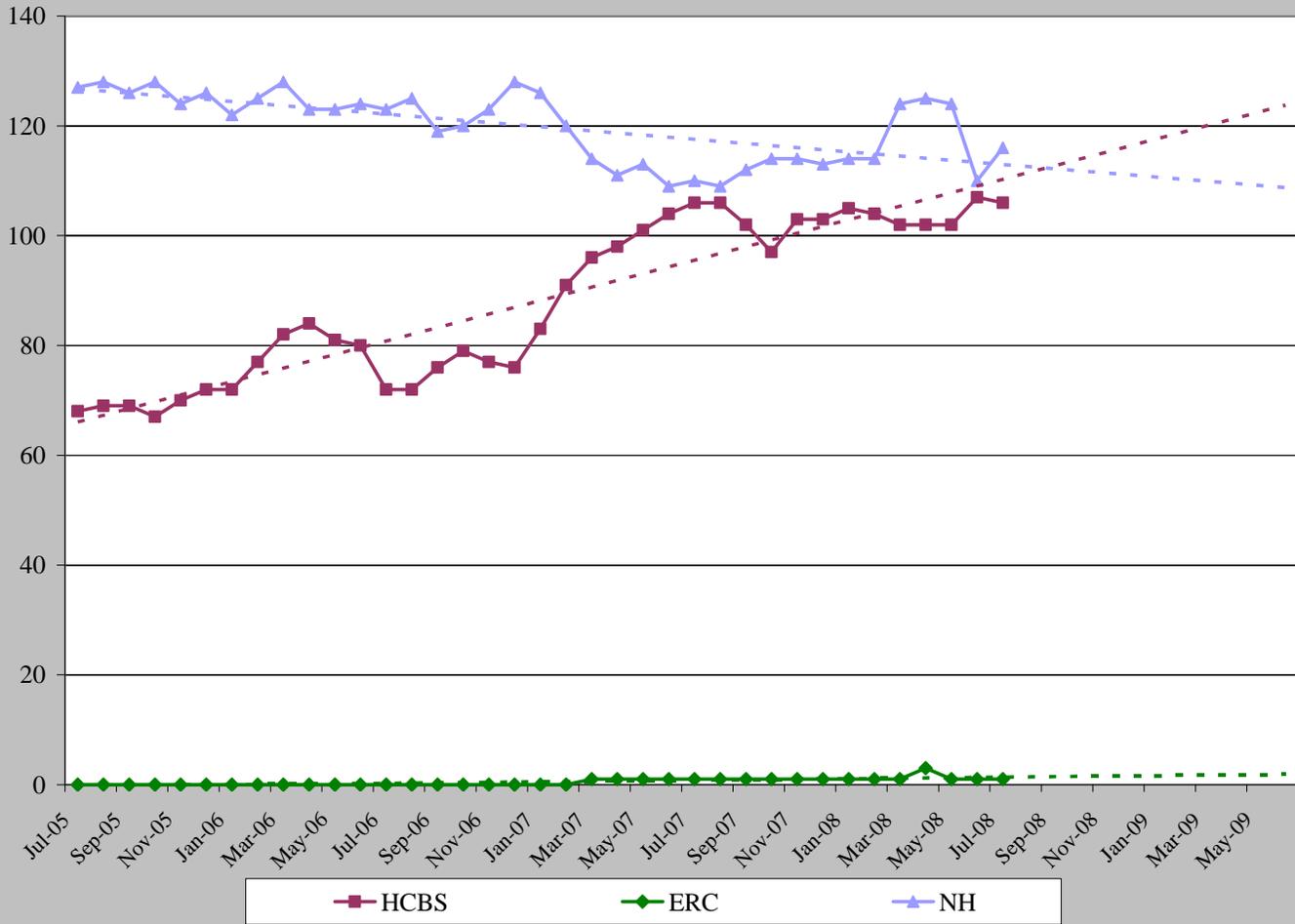


Data source: EDS paid claims

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

### Caledonia County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

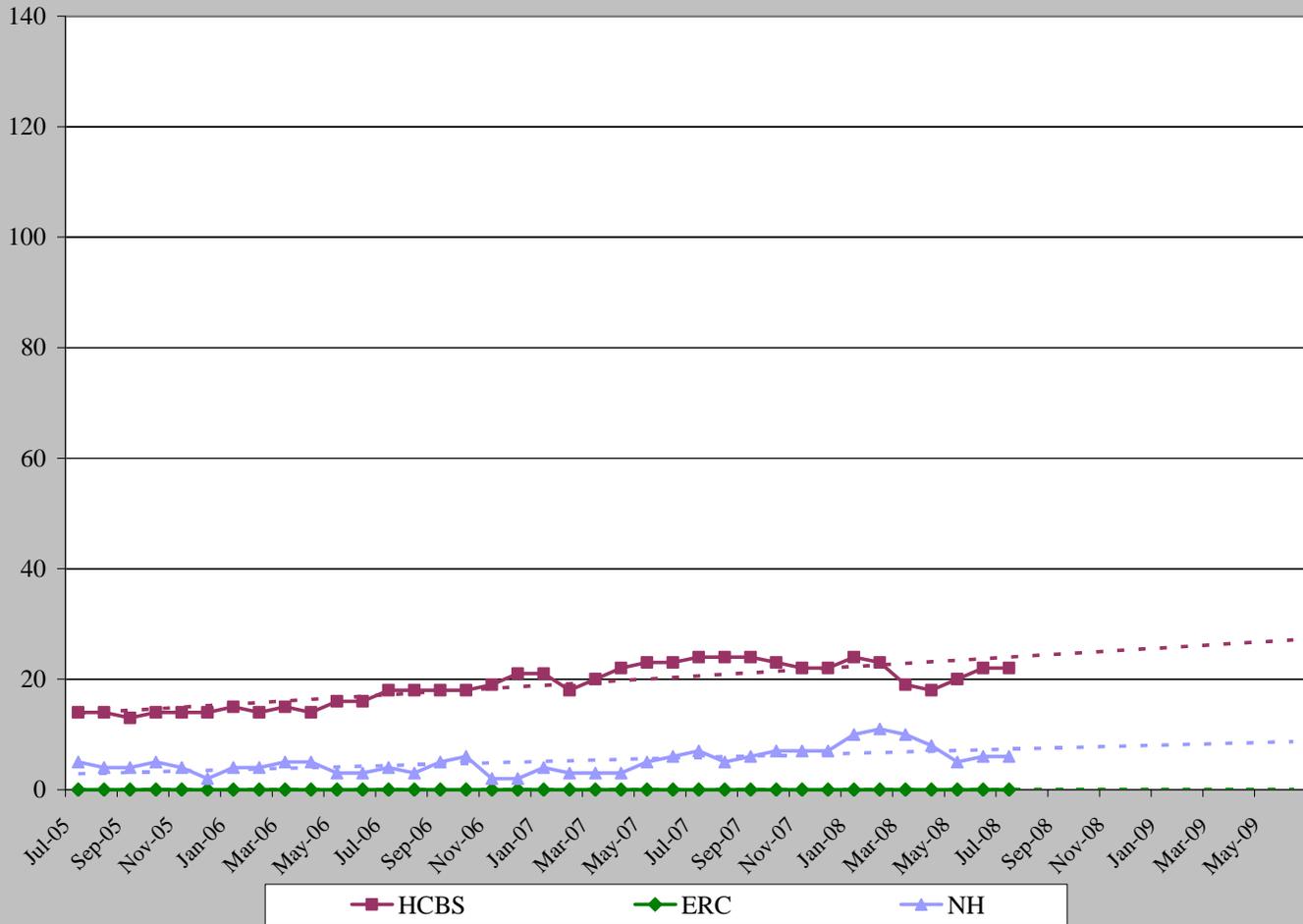


*Data source: EDS paid claims*

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

### Essex County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

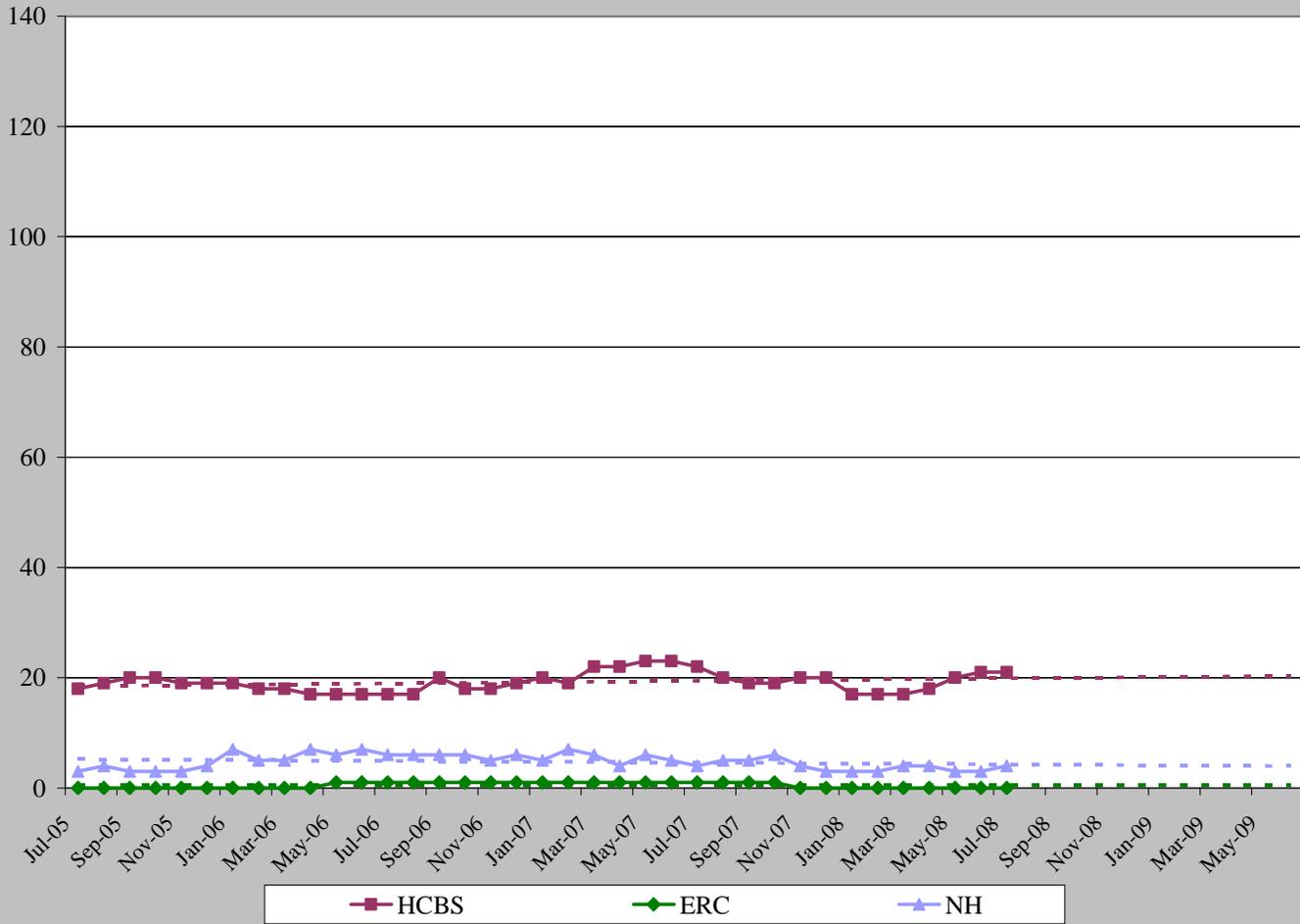


*Data source: EDS paid claims*

In Essex County, use of HCBS has increased since July 2005. The use of nursing facilities has also increased. (The use of ERC is zero, due to the absence of a participating facility in the county.) The small numbers of people served, as well as recent decreases in the use of both settings, make it difficult to determine if the expected outcome of Choices for Care has been realized in Essex County.

### Grand Isle County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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

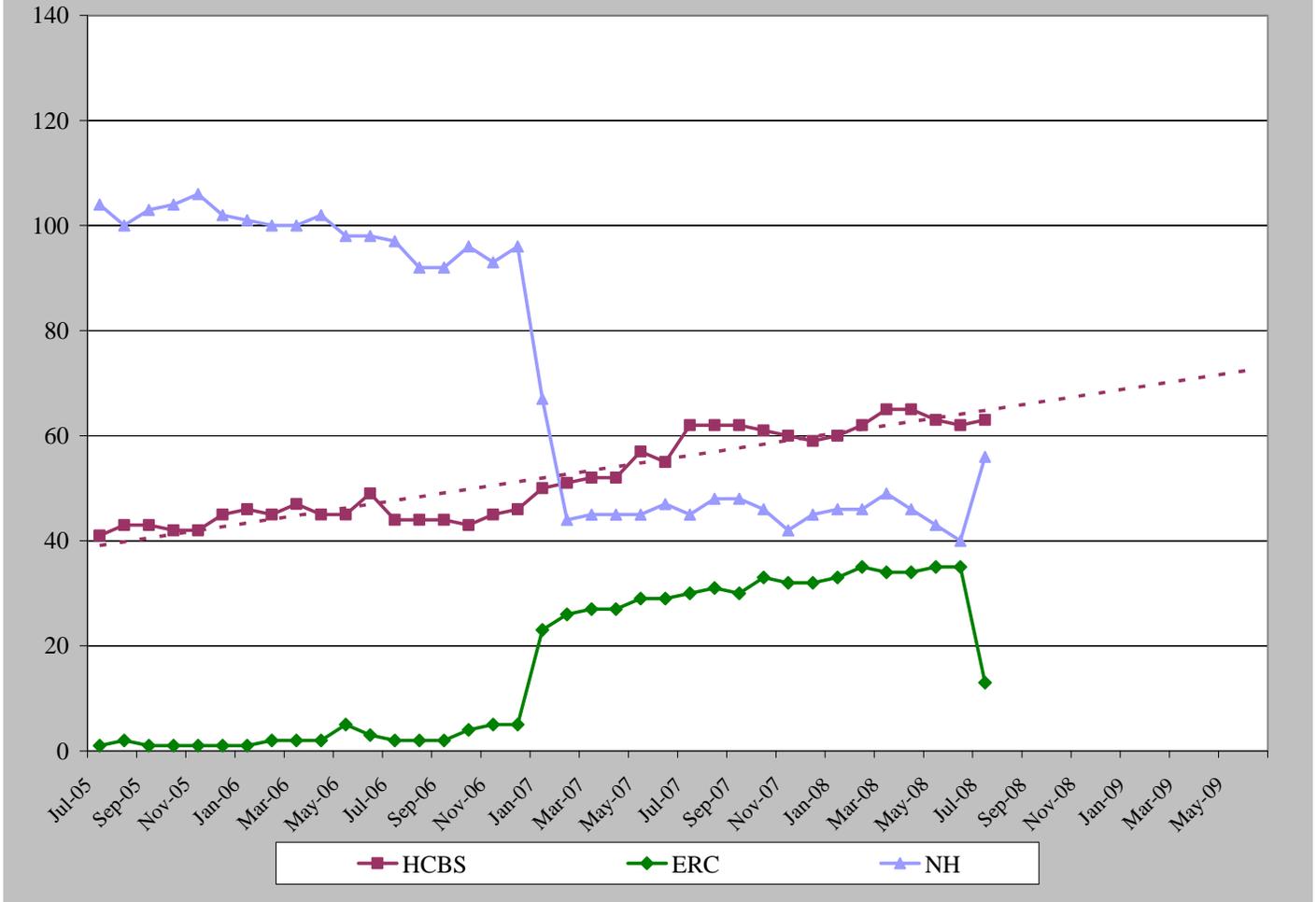


*Data source: EDS paid claims*

In Grand Isle County, use of HCBS is about the same as it was in July 2005. The use of nursing facilities has also remained stable. (The use of ERC is close to zero, due to the absence of a participating facility in the county.) The small numbers of people served make it difficult to determine if the expected outcome of Choices for Care has been realized in Grand Isle County.

### Lamoille County: Choices for Care Participants by Setting, sfy2005 - sfy2009

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



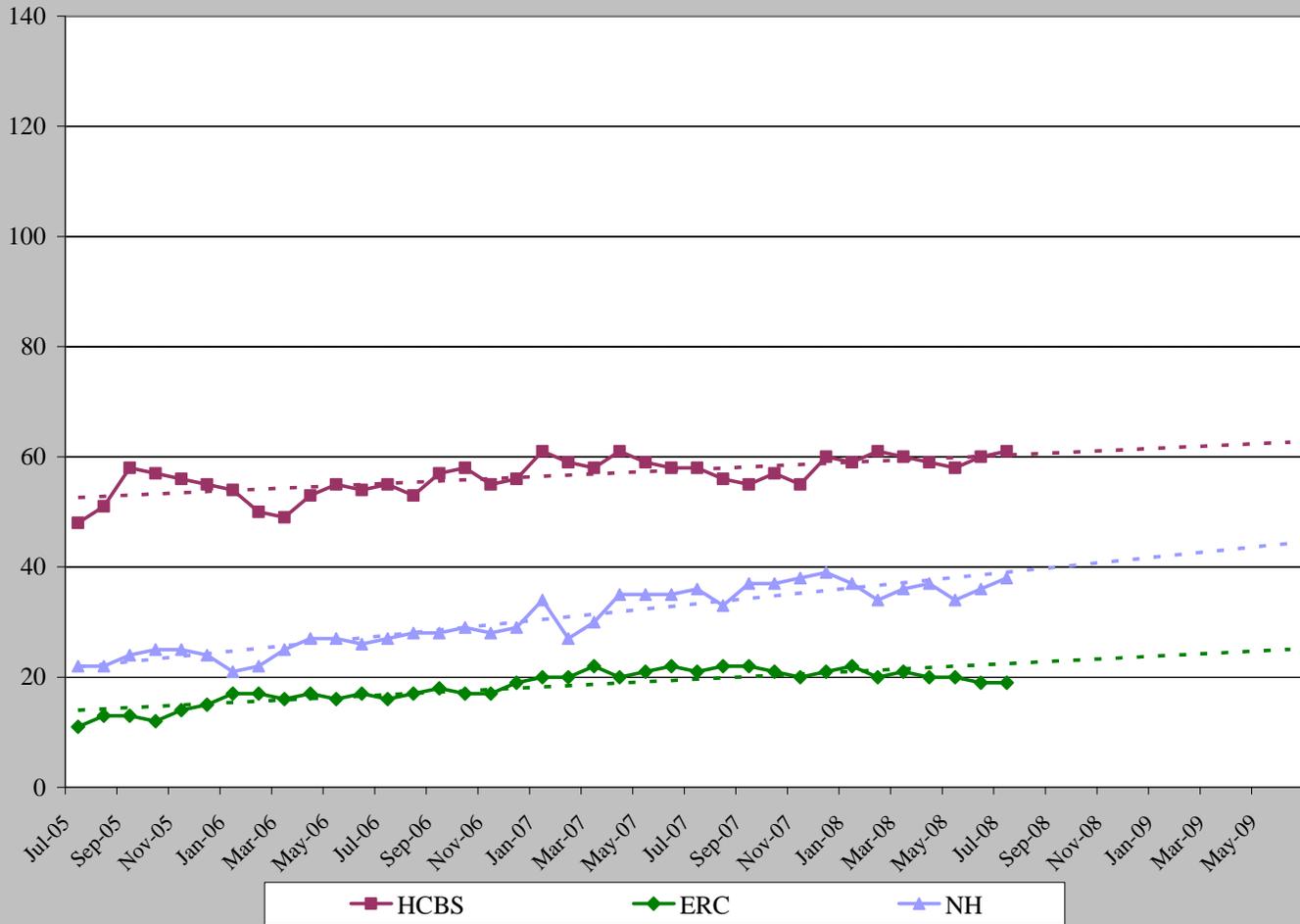
*Data source: EDS paid claims*

In Lamoille County, the closing of the Morrisville Center facility in February 2007 had a complex effect on the use of long term care services. Immediately following this nursing home closure, there was a significant decrease in the use of nursing homes and a significant increase in the use of ERC, when some residents moved to Copley Manor Spruce House. In July 2008, these ERC beds changed licensure to NF beds- increasing the use of nursing homes, and decreasing the use of ERC.

Over all, since July 2005 the use of HCBS has increased, the use of ERC has increased, and the use of nursing homes has decreased. This is the expected outcome of Choices for Care.

### Orange County: Choices for Care Participants by Setting, sfy2005 - sfy2009

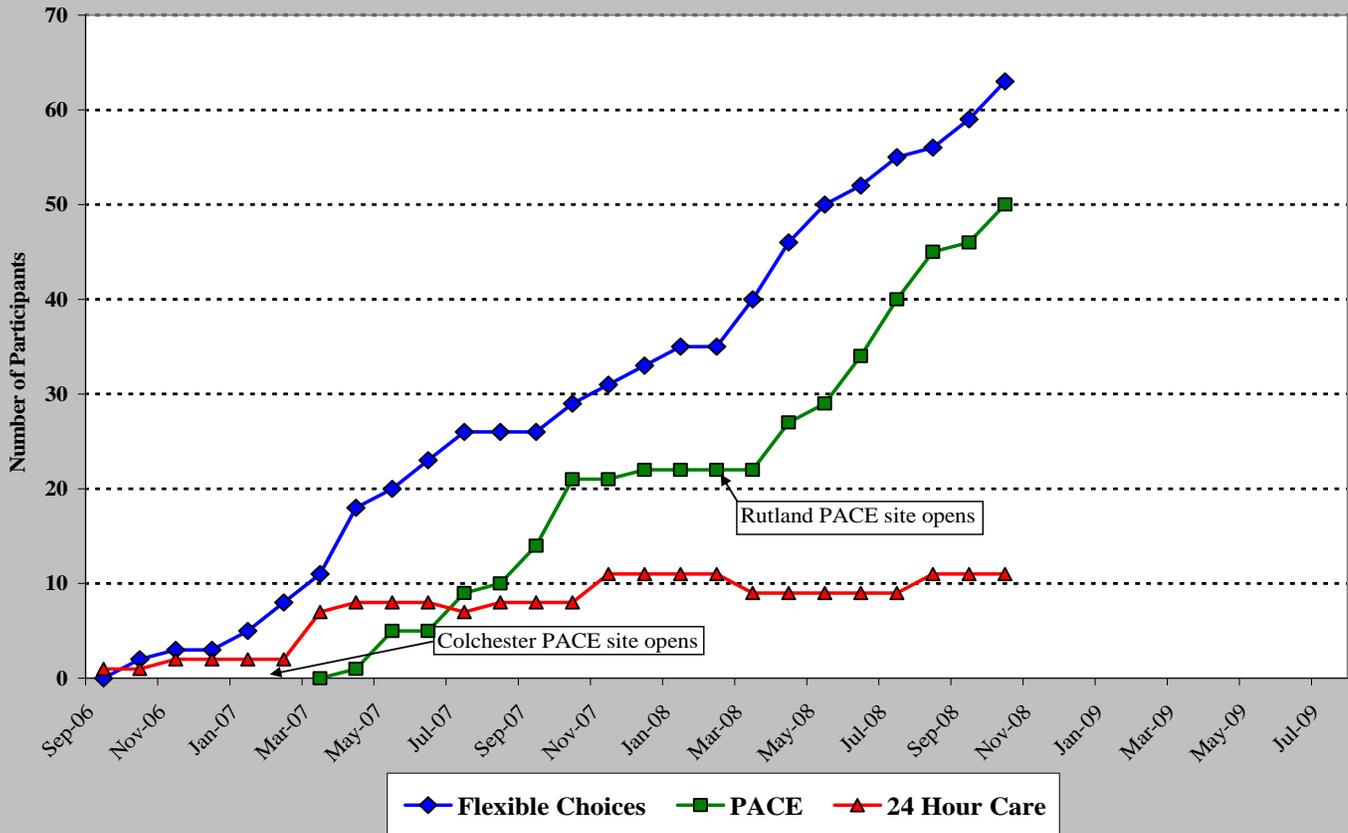
*data source: EDS paid claims by dates of service; excludes moderate needs group*



*Data source: EDS paid claims*

In Orange County, use of both HCBS and ERC has increased since July 2005. However, the use of nursing homes has also increased. It appears that the expected outcome of Choices for Care has not been realized in Orange County.

**Choices for Care: Expansion of New Service Options, sfy2007-sfy2009**  
**Flexible Choices, PACE, and HCBS 24-Hour Care Active Enrollments**  
*September 2006 - October 2008*

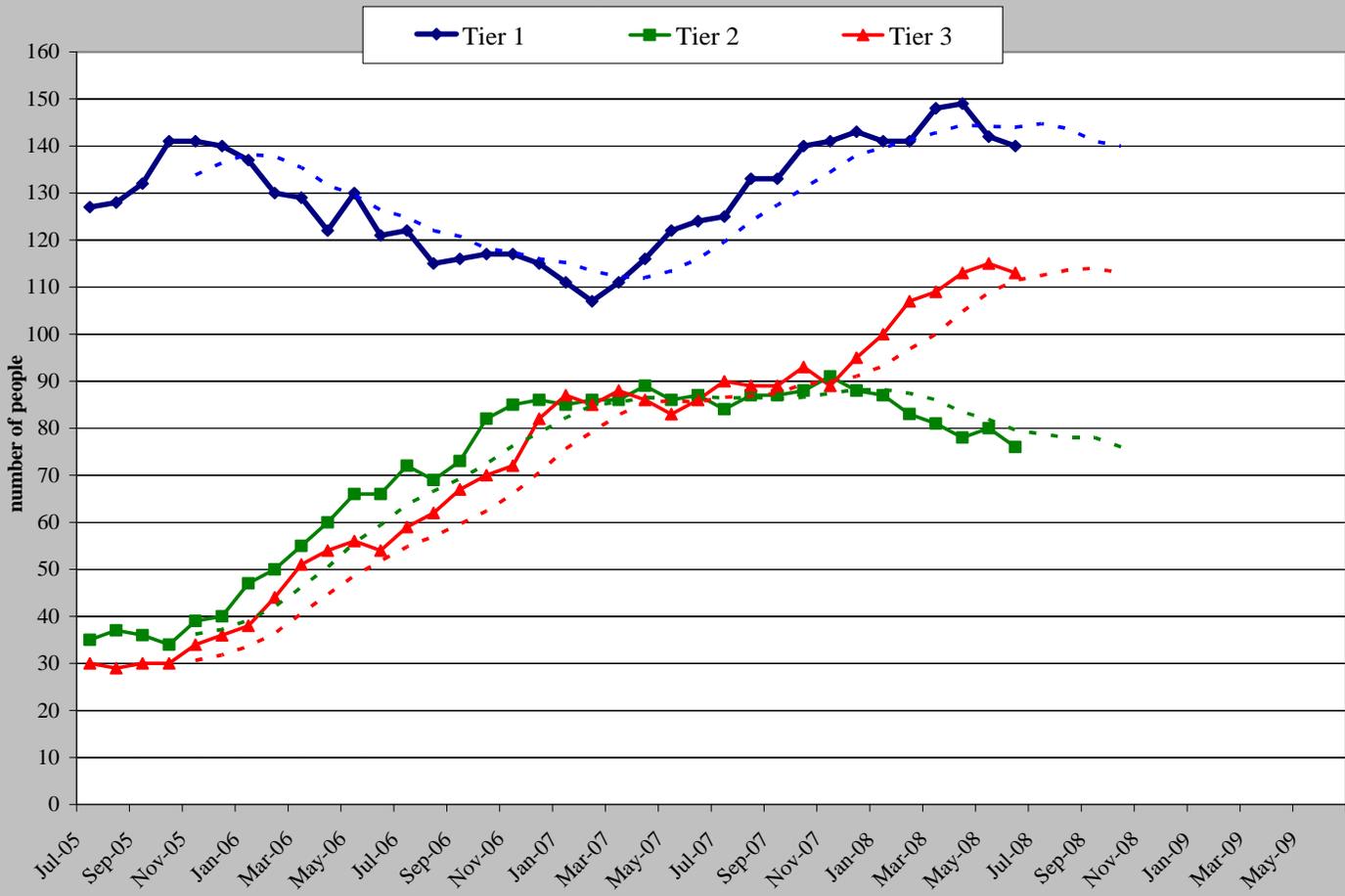


Data source: DAIL/DDAS SAMS database

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

A fourth option has also been developed under Choices for Care. Medicaid laws and regulations prohibit caregiving payments to spouses (except under extraordinary circumstances). However, this prohibition can be ‘waived’ through an 1115 Waiver, and in May 2007 Choices for Care implemented a policy that allows spouses to be paid to provide personal care. Several factors (including eligibility restrictions on household income and the presence of a spouse who is available and able to provide care) are expected to limit the number of people who choose this service option. While complete data on the number of spouses who are paid to provide care does not exist, Choices for Care staff have implemented a method to do this, and data will be available in the future.

## Choices for Care: Enhanced Residential Care Participants by 'Tier' July 2005 - June 2009

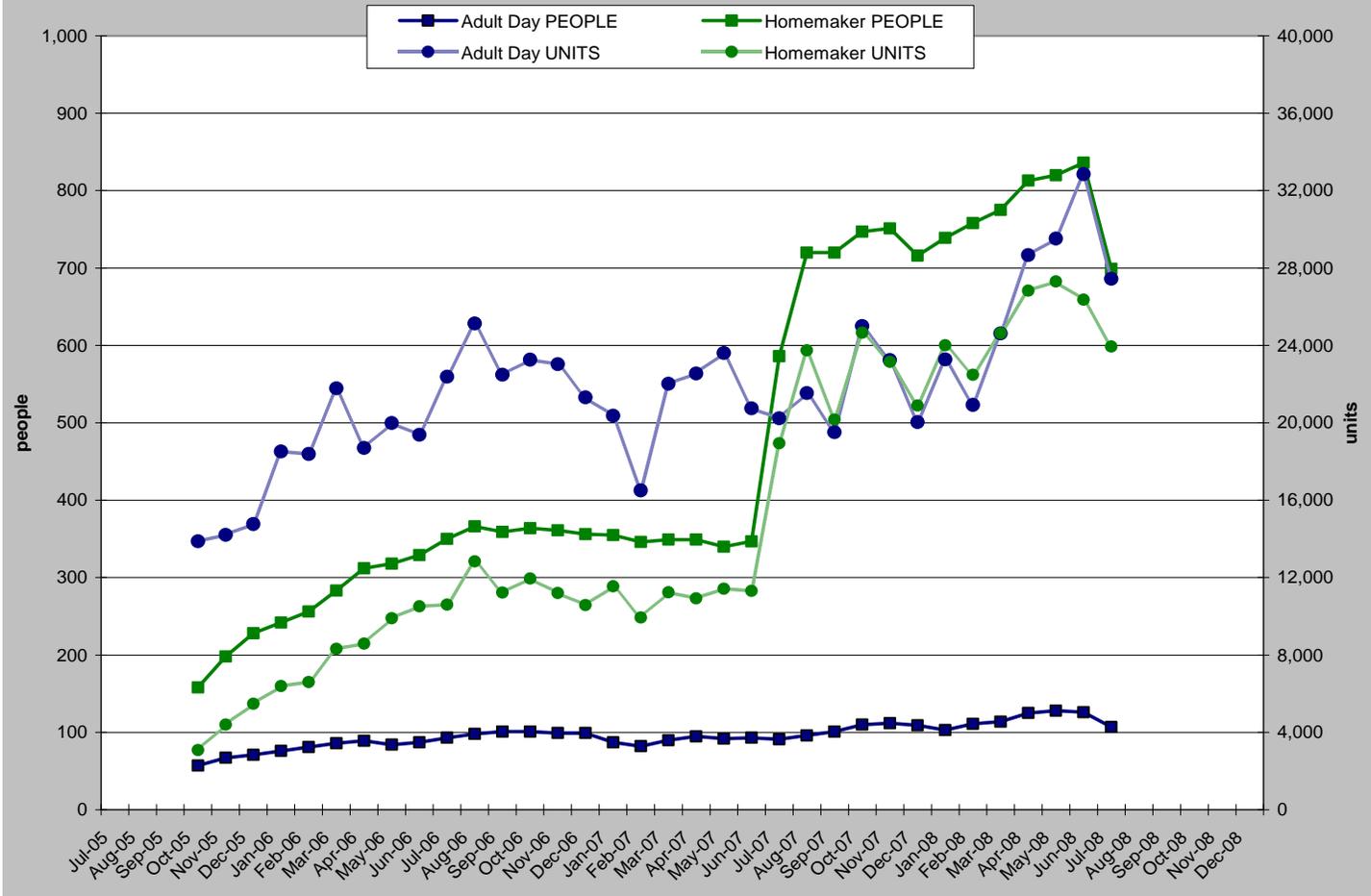


Data source: EDS paid claims, by date of service

Reimbursement for Enhanced Residential Care services is made through three ‘tiers’ that represent the resident’s level of need. Tier 1 represents the lowest level of need, with the lowest reimbursement rate. Tier 3 represents the highest level of need, with the highest reimbursement rate.

The number of people in Tier 1 slowly decreased in the first 18 months, and has increased since then. The number of people in Tier 2 increased for the first year, remained fairly stable for over a year, and has since begun to decrease. The number of people enrolled in Tier 3 has increased dramatically, from about 30 people to about 110 people. This suggests that ERC represents a viable alternative to a nursing home for some people with relatively high needs.

## Choices for Care Moderate Needs Group Services



Data source: EDS paid claims, by date of service

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

The number of MNG participants using Adult Day grew steadily from October 2005 through August 2006, and has remained near 100 people per month since then. Adult Day service hours have averaged about 14 hours per week per person in the last year.

The number of MNG participants using Homemaker grew steadily from October 2005 through August 2006. The number of people served each month then decreased slowly from August 2006 until July 2007, when an influx of new funding caused a rapid increase to more than 800 people. Homemaker service hours have averaged about 2 hours per week per person in the last year.