



Choices for Care

Quarterly Data Report

January 2009

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

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

We welcome your comments, questions and suggestions.

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Note:

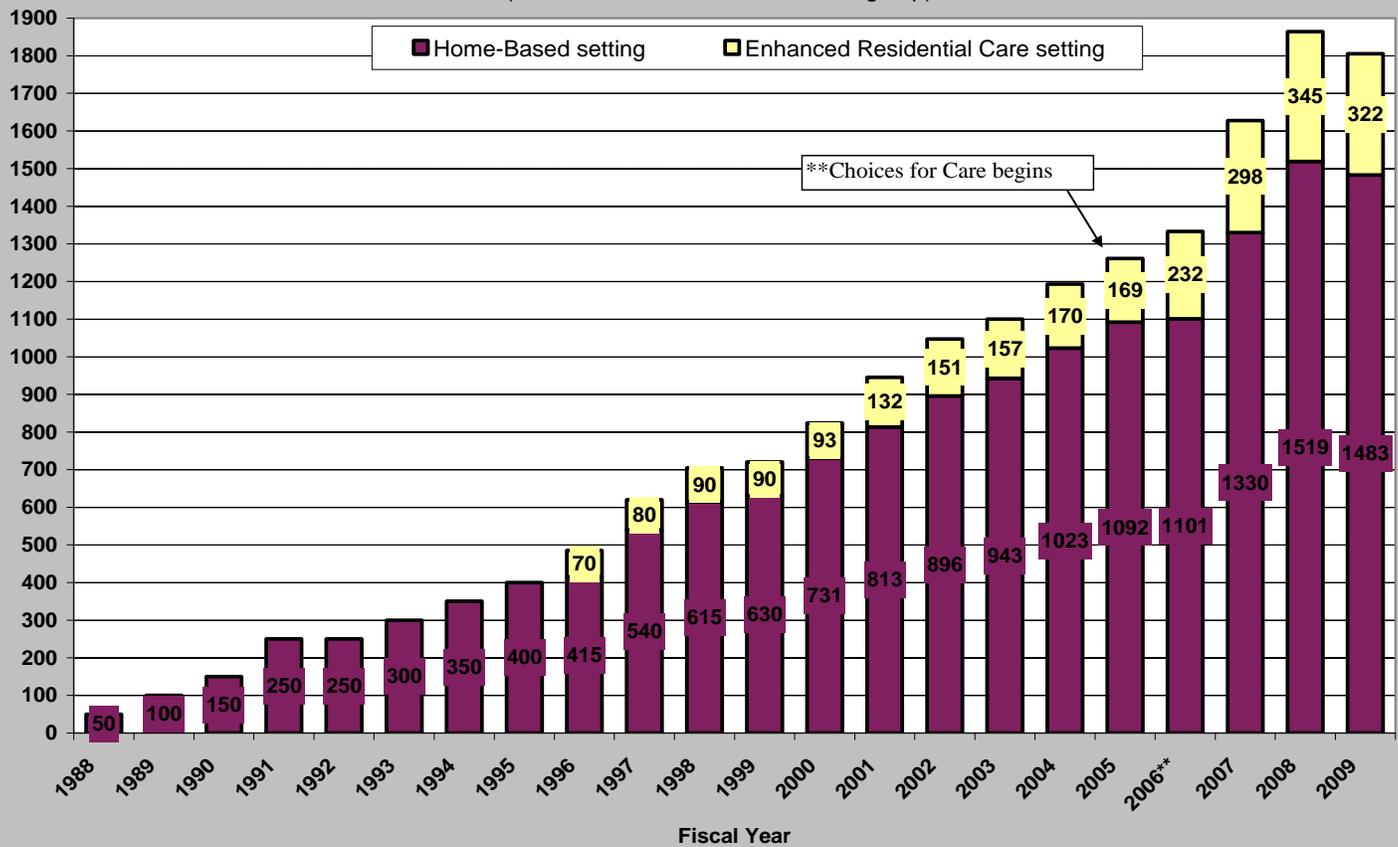
Vermont tracks a variety of process and reviews outcomes in a variety of areas in order to manage the Choices for Care Waiver. These include, but are not limited to:

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 Point-in-Time by Year, sfy1988-sfy2009

(does not include moderate needs group)



Data source: DAIL/DDAS databases

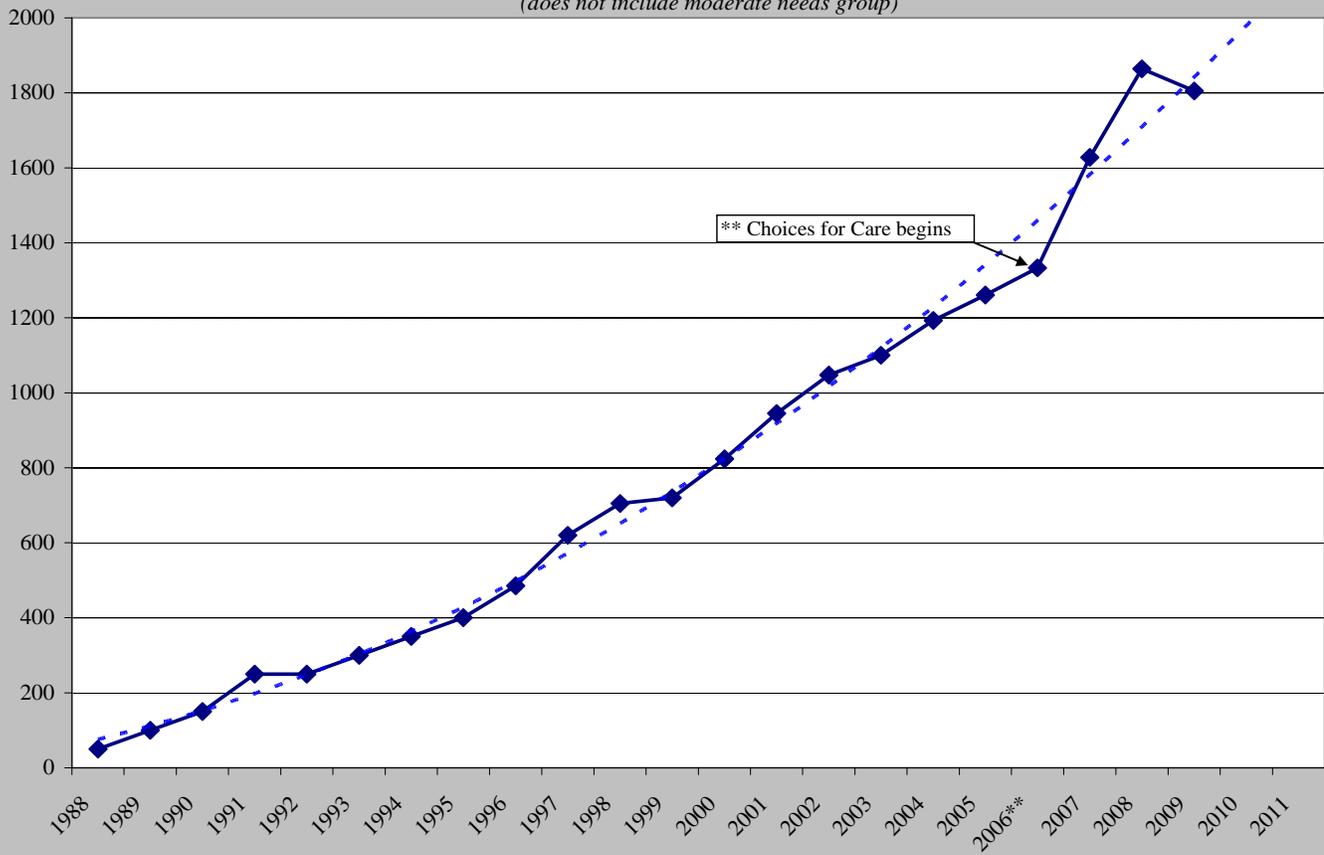
This graph illustrates the growth in home and community based services in Vermont since SFY1988.

Prior to the implementation of Choices for Care in October 2005, the number of people served increased fairly steadily, but this growth was 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 SFY2007, the number of people enrolled in alternative settings increased by nearly 300, followed by an increase of nearly 240 in SFY2008. These increases were significantly higher than in previous years, with annual increases approaching 20%. In SFY2009 the number of people decreased for the first time, as a result of the waiting list for the High Needs Group.

Numbers of People Served in Aging/Disabled Medicaid Waivers Maximum Point-in-Time by Year, sfy1988-sfy2009

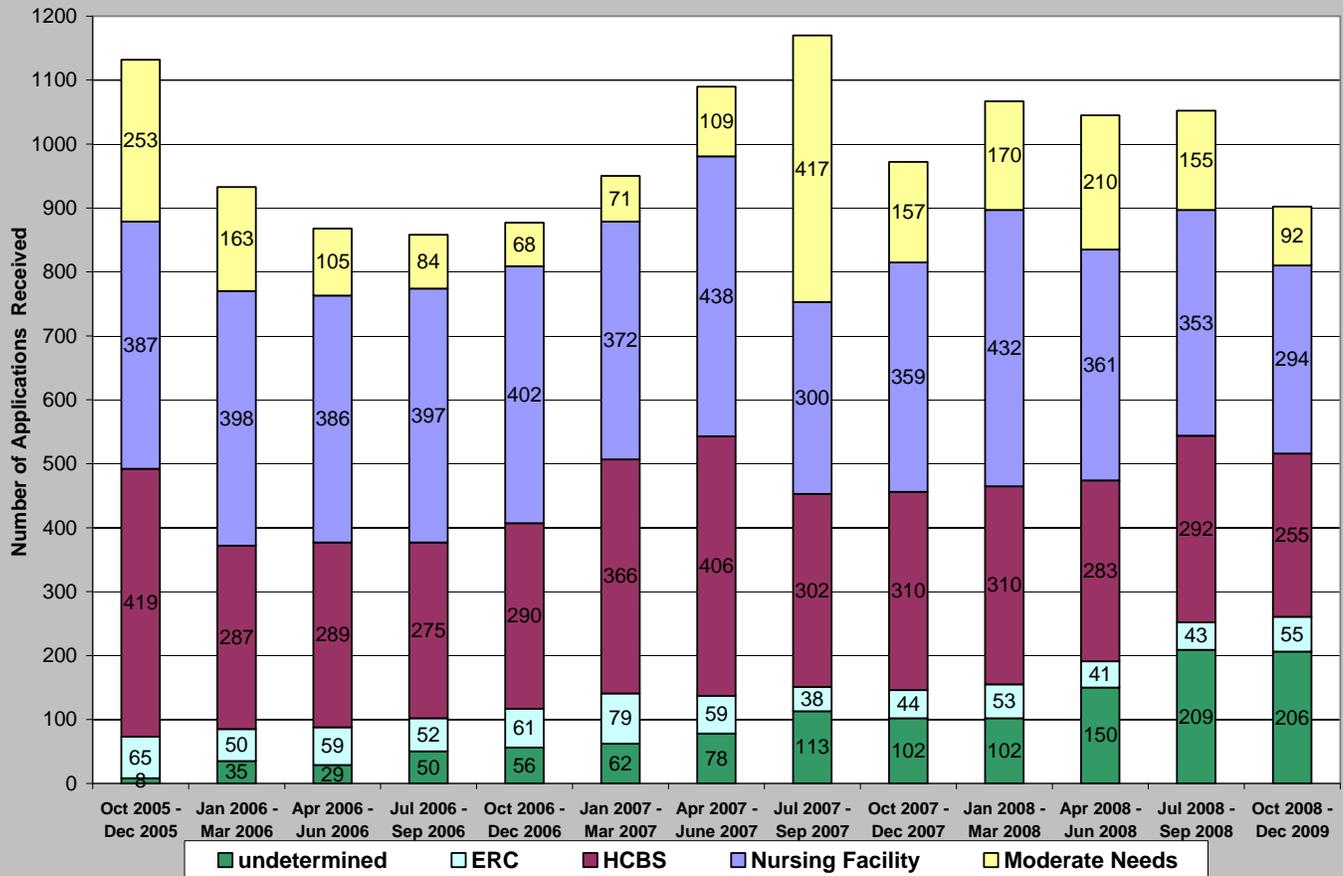
(does not include moderate needs group)



Data source: DAIL/DDAS databases

This graph combines HBS and ERC enrollment, and projects enrollment trends through SFY2011. Enrollment in these alternative settings grew more quickly following the implementation of Choices for Care (SFY2006-SFY2008) than at any other time in the past. Future enrollment will be highly influenced by funding levels and the presence or absence of a High Needs Group waiting list.

**Choices for Care: Applications Received by Service Program
October 1, 2005 through January 1, 2009**

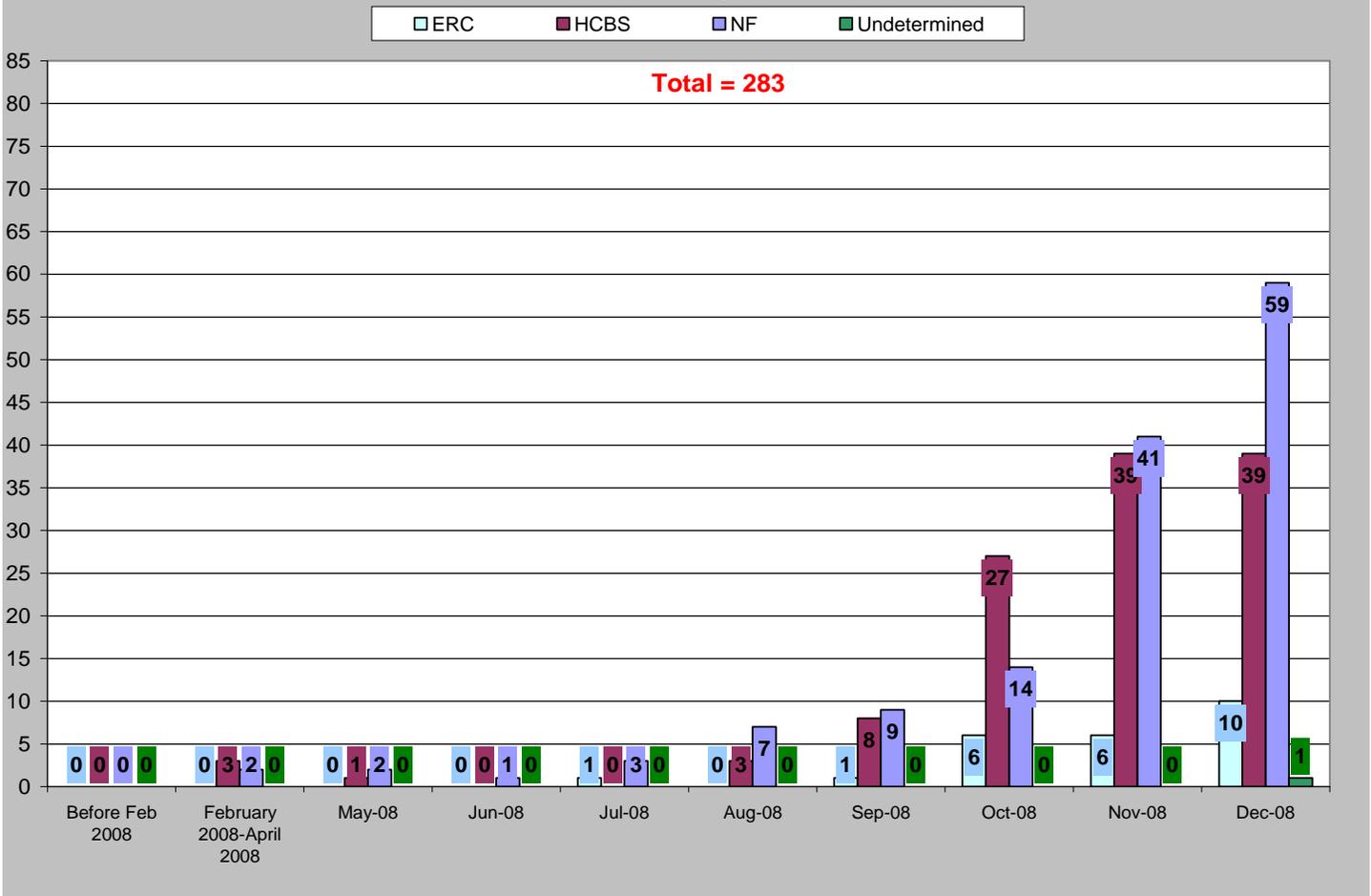


Data source: DAIL/DDAS SAMS database.

The number of applications has remained fairly stable over time. The average number of applications received each month, by fiscal year:

Setting	SFY2006	SFY2007	SFY2008	SFY2009
undetermined	8	21	39	69
ERC	19	21	15	16
HBS	111	111	100	91
Nursing Facility	130	134	121	108
Moderate Needs Group	58	28	80	41
TOTAL	326	315	355	326

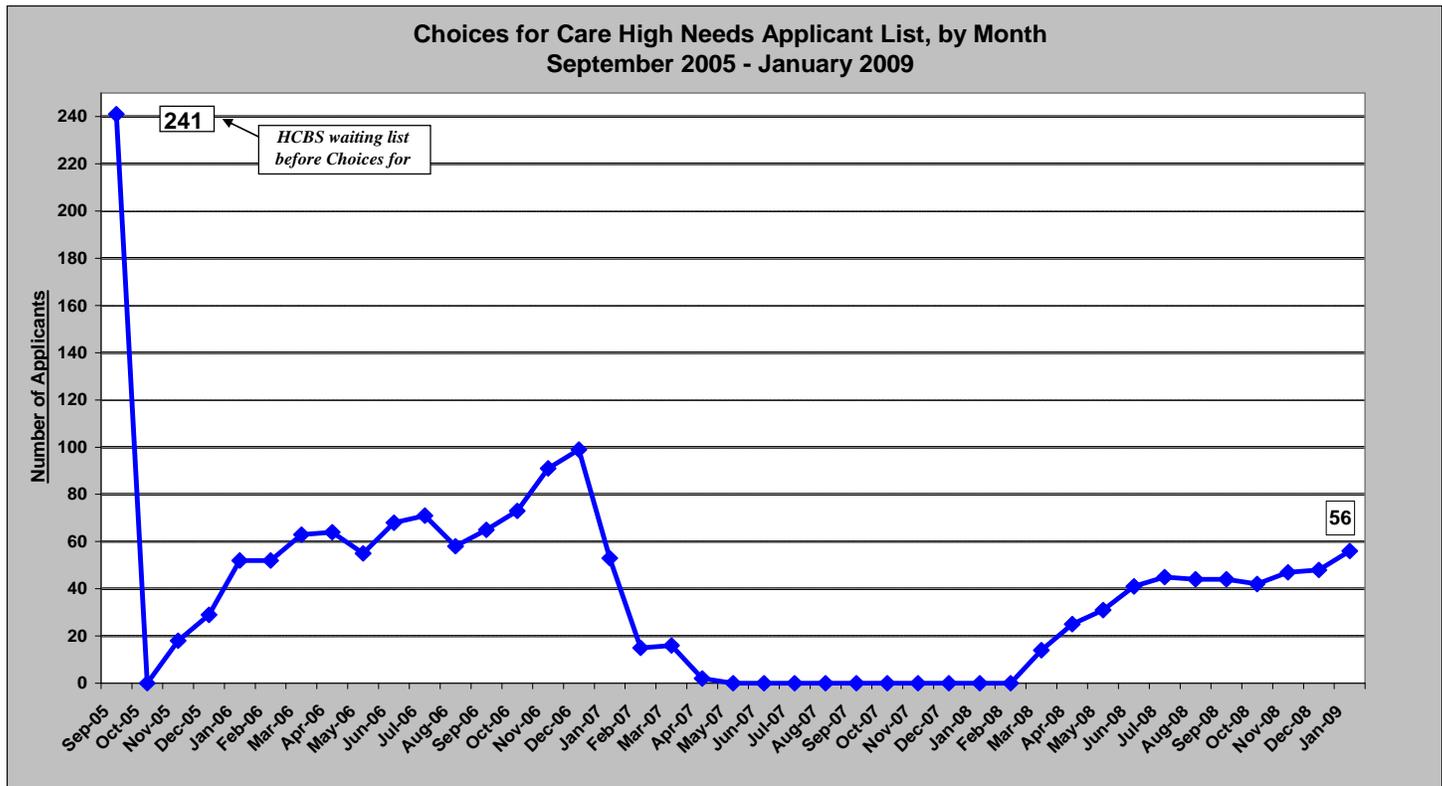
**Choices for Care: Applications 'Pending Medicaid' by Status Date
October 2005 through December 2008
as of January 2009**



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.



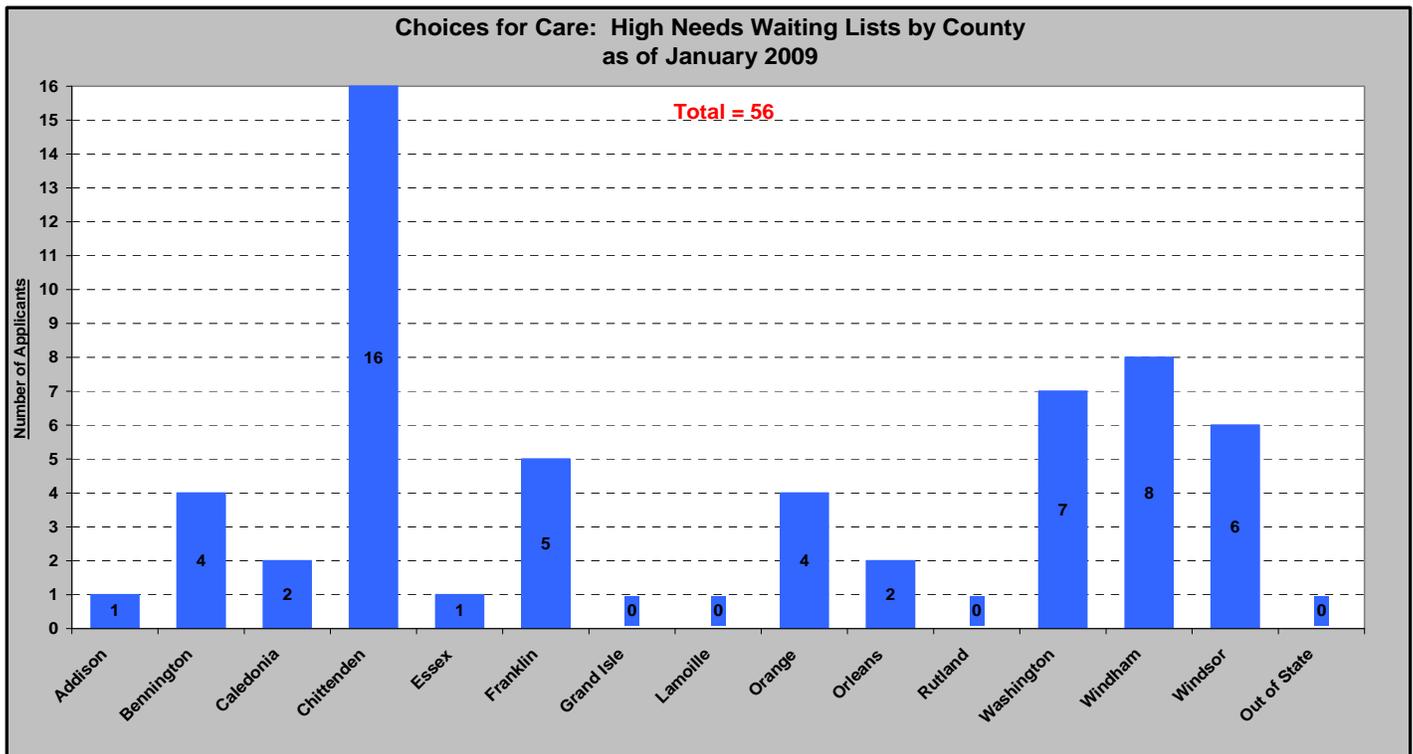
Data source: DAIL/DDAS SAMS database.

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 HBS 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 HBS and ERC, 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 affects 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, in the context of positive expenditure trends the legislature directed DAIL to enroll all High Needs Group applicants, 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 this waiting list will continue for the foreseeable future.



Data source: DAIL/DDAS SAMS database.

This graph shows the distribution of the High Needs Group waiting list by county. The waiting lists in Chittenden, Windham and Windsor counties are disproportionately large. The waiting lists in Addison, Lamoille, and Rutland are disproportionately low. This may reflect regional differences in the intended use of Choices for Care and/or differences in access to other services as alternatives to Choices for Care.

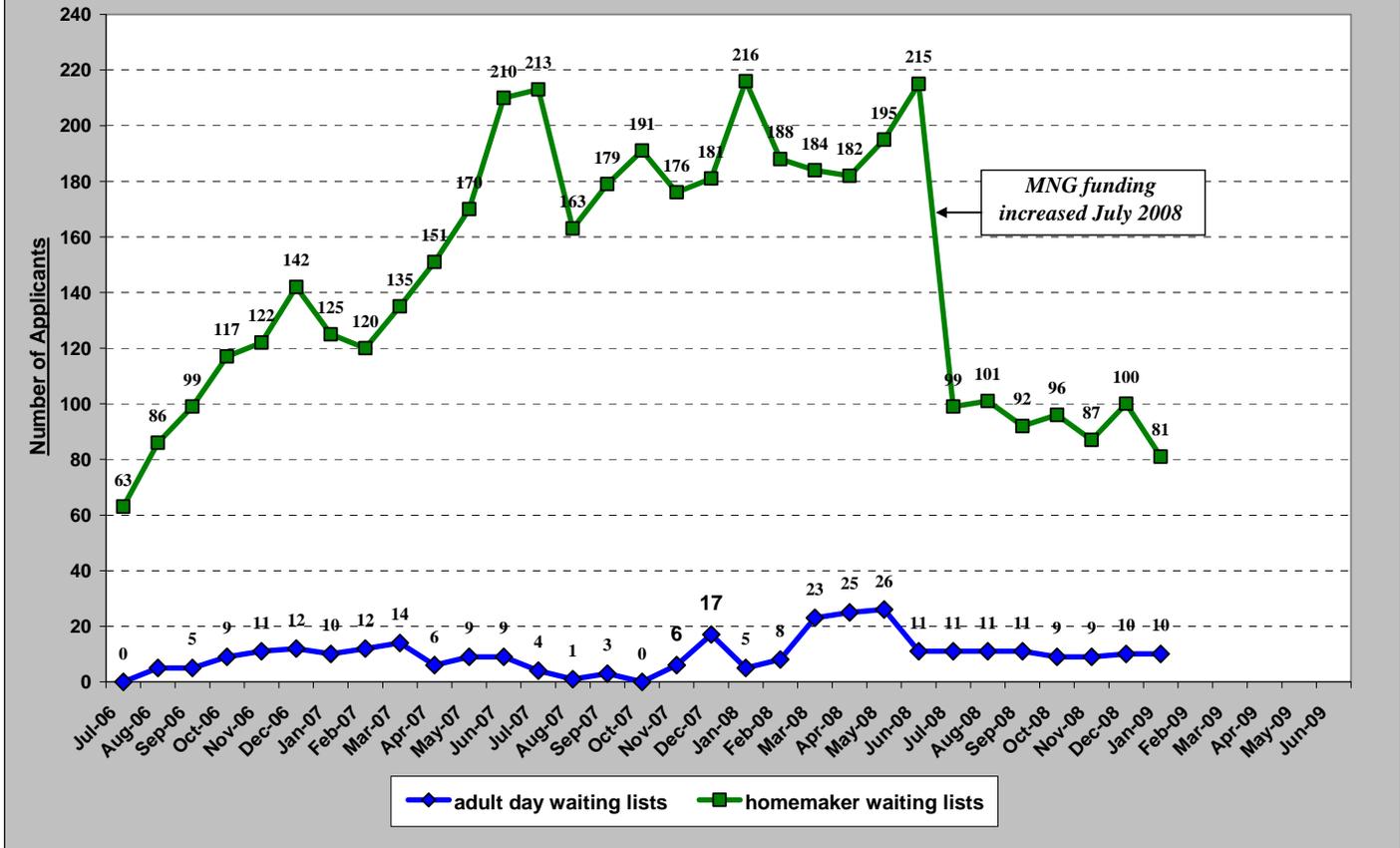
Because people's needs change, it is important that case managers monitor the status and circumstances of people who are on the waiting lists. Case managers also help to identify those people who should be served under special circumstances, or people whose needs have changed such that they meet the eligibility criteria for the Highest Needs Group.

Other aspects of the waiting list data are of interest. 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 about 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. What happened to the hundreds of people in the High Needs Group who would have been expected to apply, but did not? There are several explanations:

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, as before.

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



5.

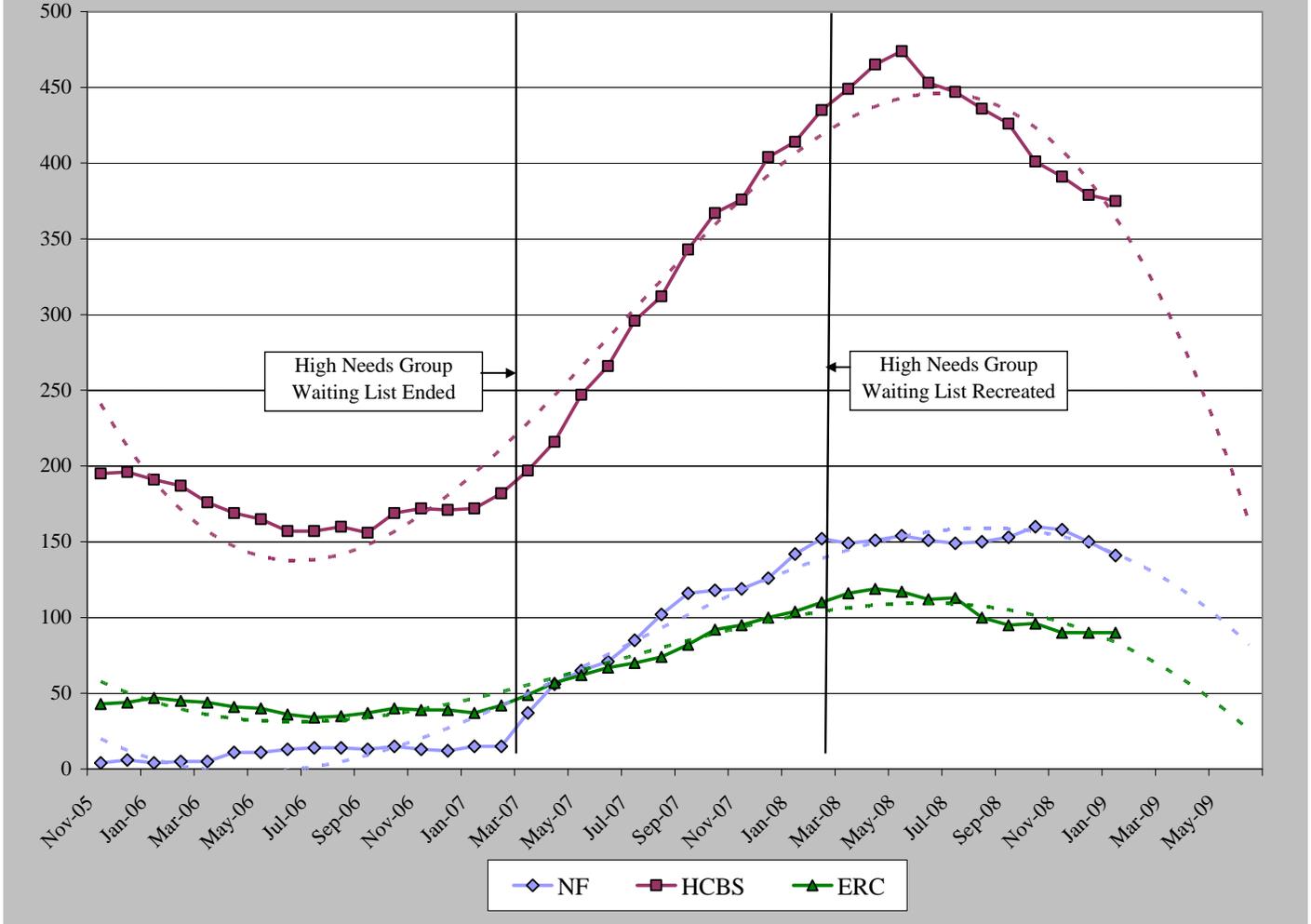
Data source: waiting list reports from home health agencies and adult day programs.

This graph shows the numbers of people placed on waiting lists for Moderate Needs Group Homemaker and Adult Day Services. The graph starts in July 2006, when providers began to submit monthly waiting list data to the DAIL Division of Disability and Aging Services (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 January 2009. The number of people on the Homemaker waiting lists ranged from 6 to 157. 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 over time, but has never exceeded 26 people. Of the fourteen Adult Day providers, two reported waiting lists in January 2009, showing 2 people and 8 people.

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



Data source: DAIL/DDAS SAMS database.

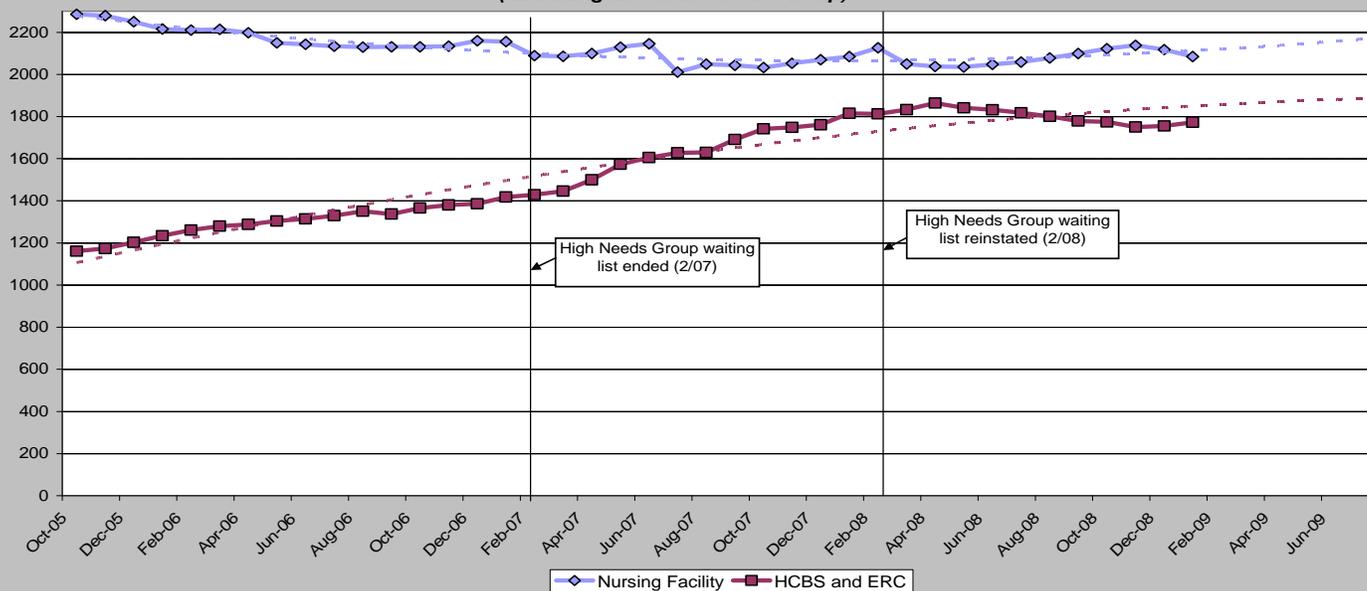
When the initial waiting list was lifted, High Needs Group enrollment increased by 458 people, or nearly 200%. The largest increase occurred in the HBS setting.

When the waiting list was recreated in February 2008, enrollment began to fall, although the decrease did not begin until several months had passed. This delayed effect on enrollment was caused by the length of time required for all eligibility processes to be completed; changes in expenditures are delayed even longer. This shows that the effects of policy and eligibility changes are not seen for several months, and may not be substantial for six months or longer.

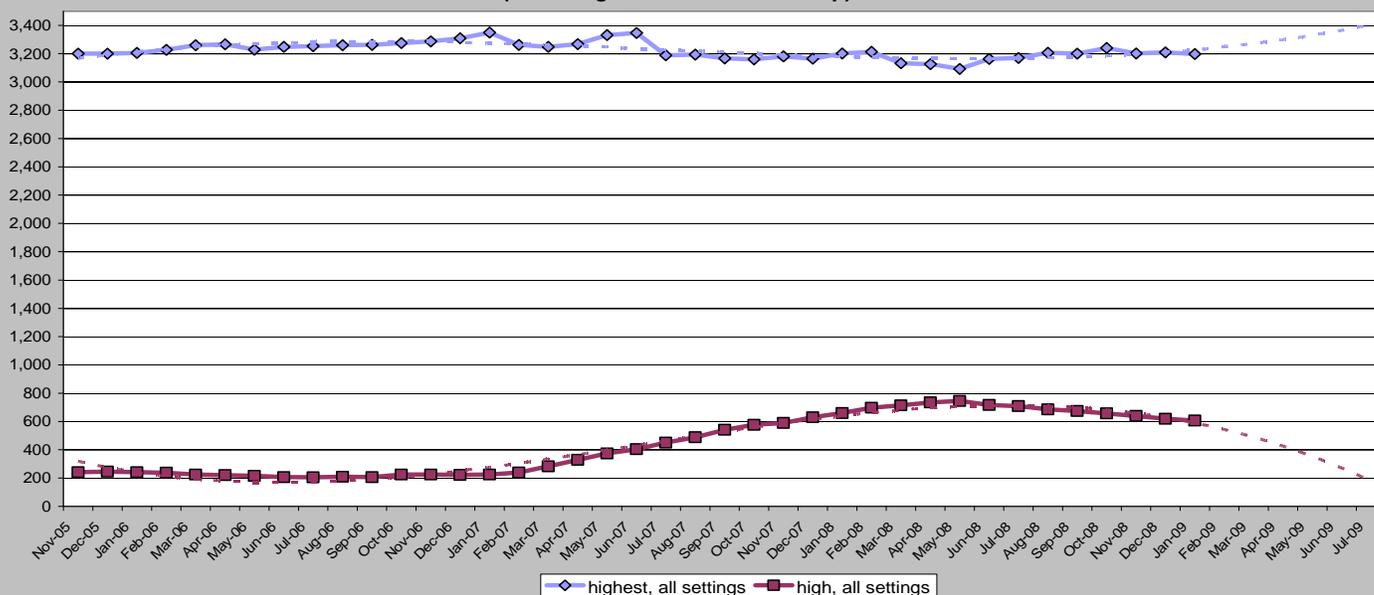
These data suggest:

1. The High Needs Group waiting list will continue to reduce total enrollment and expenses in SFY2009. The waiting list does appear to serve as a financial “safety valve” as intended.
2. The largest decrease in High Needs Group enrollment will occur in the HBS setting.

Choices for Care: Enrolled Participants by Setting
October 2005 - January 2009
(excluding Moderate Needs Group)



Choices for Care: Enrolled Participants by Needs Group
October 2005 - January 2009
(excluding Moderate Needs Group)

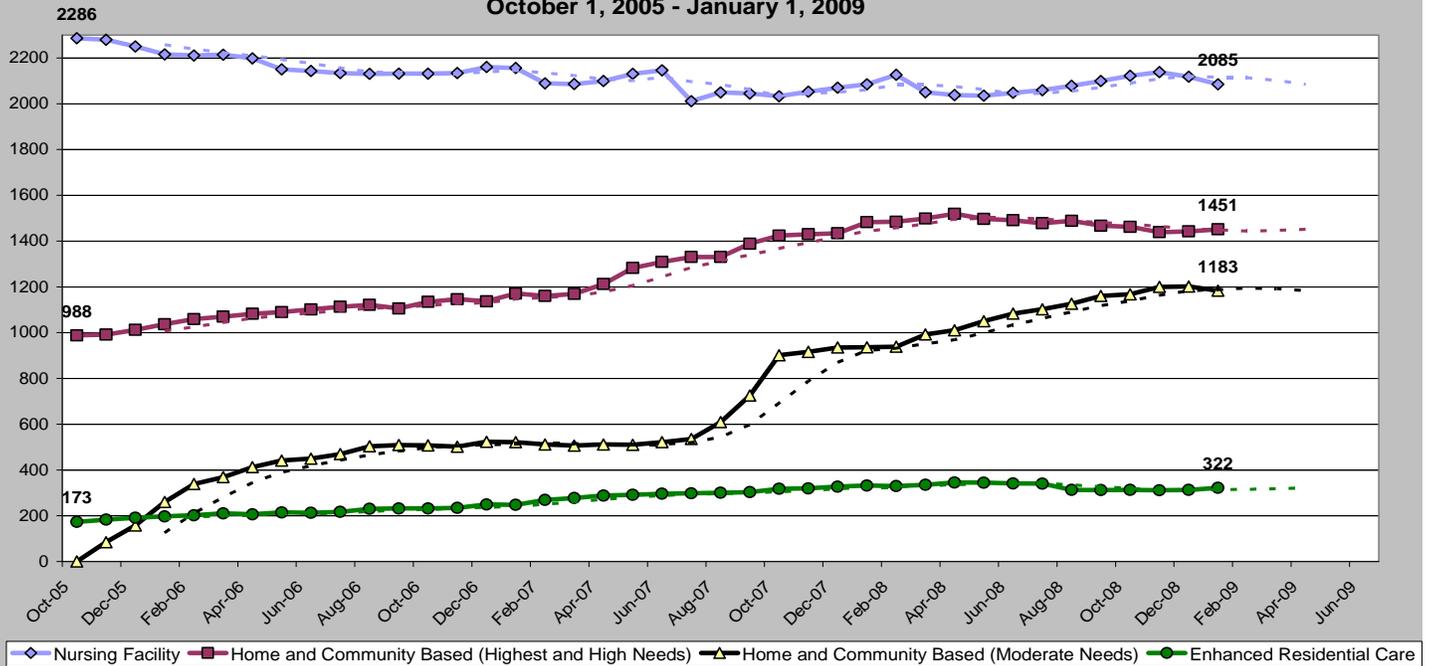


Data source: DAIL/DDAS SAMS database.

These graphs show trends in enrollment of people in the Highest Needs Group and the High Needs Group. These groups meet the ‘traditional’ nursing home clinical and functional eligibility criteria. The two data sources show:

- Nursing homes: a slow decrease in the number of people enrolled through June 2008, followed by a “seasonal” increase in enrollment.
- Alternative settings: a slow increase in the number of people enrolled through April 2008. After that date enrollment slowly decreased. This was caused by the High Needs Group waiting list, as people in this group tend to choose settings other than nursing homes.

Choices for Care: Total Number of Enrolled Participants by Setting
October 1, 2005 - January 1, 2009



Data source: DAIL/DDAS SAMS database.

Nursing homes: between October 2005 and January 2009, the number of people enrolled in the nursing home setting decreased by about 200. This was associated with a decrease in Vermont nursing home capacity of 135 beds:

Oct 2005	Newport Health and Rehab	-10	Orleans
Jan 2006	Mt Ascutney	-8	Windsor
Sept 2006	Menig Extended Care	+10	Orange
Oct 2006	Burlington Health & Rehab	-42	Chittenden
Feb 2007	Morrisville/Genesis	-90	Lamoille
Aug 2007	Wake Robin	+18	Chittenden
Jan 2008	Mt Ascutney	-15	Windsor
Jan 2008	Veterans Home	-7	Bennington
April 2008	Berlin Health and Rehab	-11	Washington
April 2008	Rowan Court Health and Rehab	-8	Washington
July 2008	The Manor	+32	Lamoille
Oct 2008	Mt. Ascutney	-4	Windsor

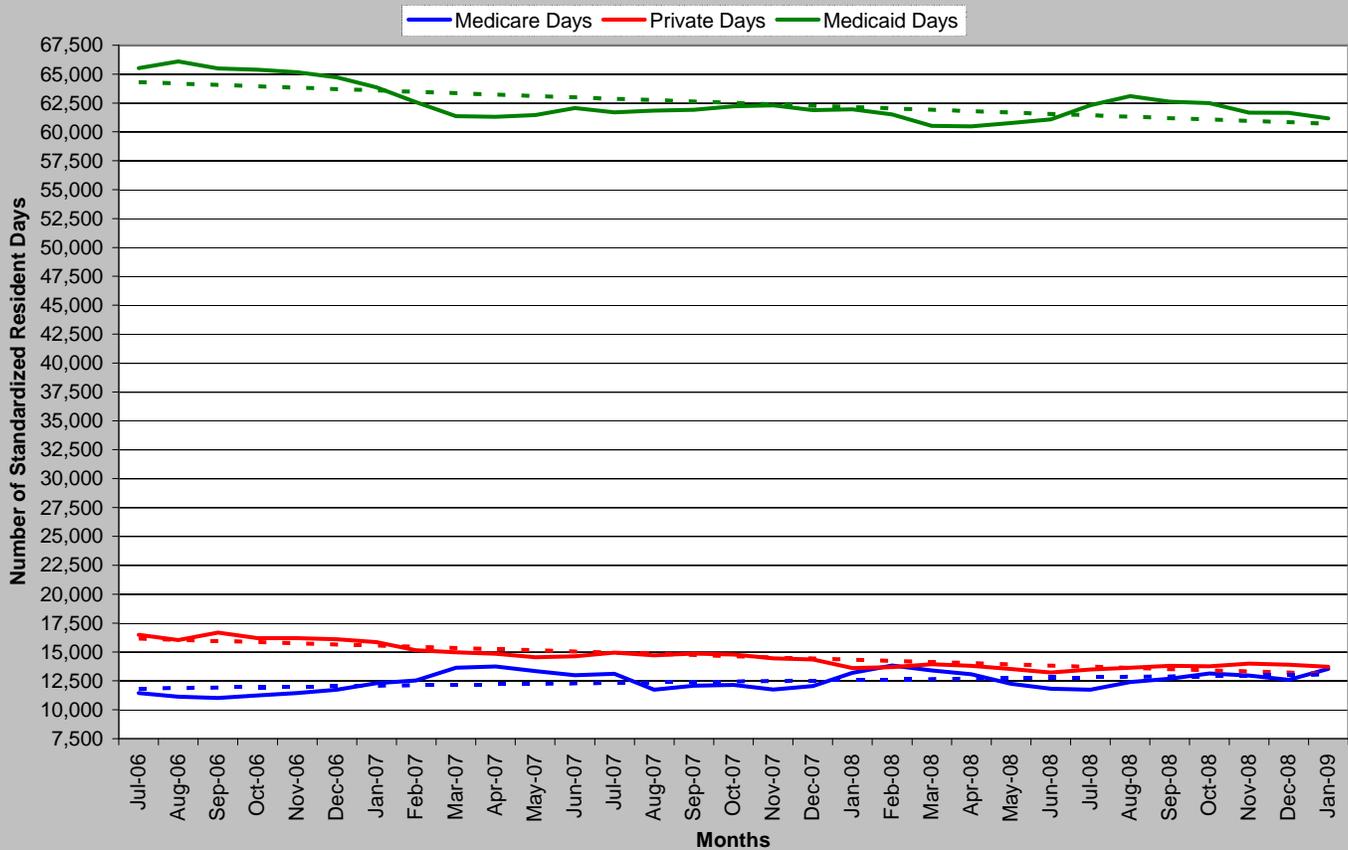
Home Based Services (Highest/High Needs Groups): between October 2005 and January 2009, the number of people enrolled in HBS increased by more than 450. The number of people has slowly decreased in the past ten months due to the High Needs Group waiting list.

Enhanced Residential Care (ERC): between October 2005 and January 2009, the number of people enrolled in ERC increased by almost 150 (nearly 100%). The number of people has slowly decreased in the past eight months due to the High Needs Group waiting list.

HBS Moderate Needs Group (MNG): 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 Homes: Standardized Resident Days, sfy2007 - sfy2009

Division of Ratesetting



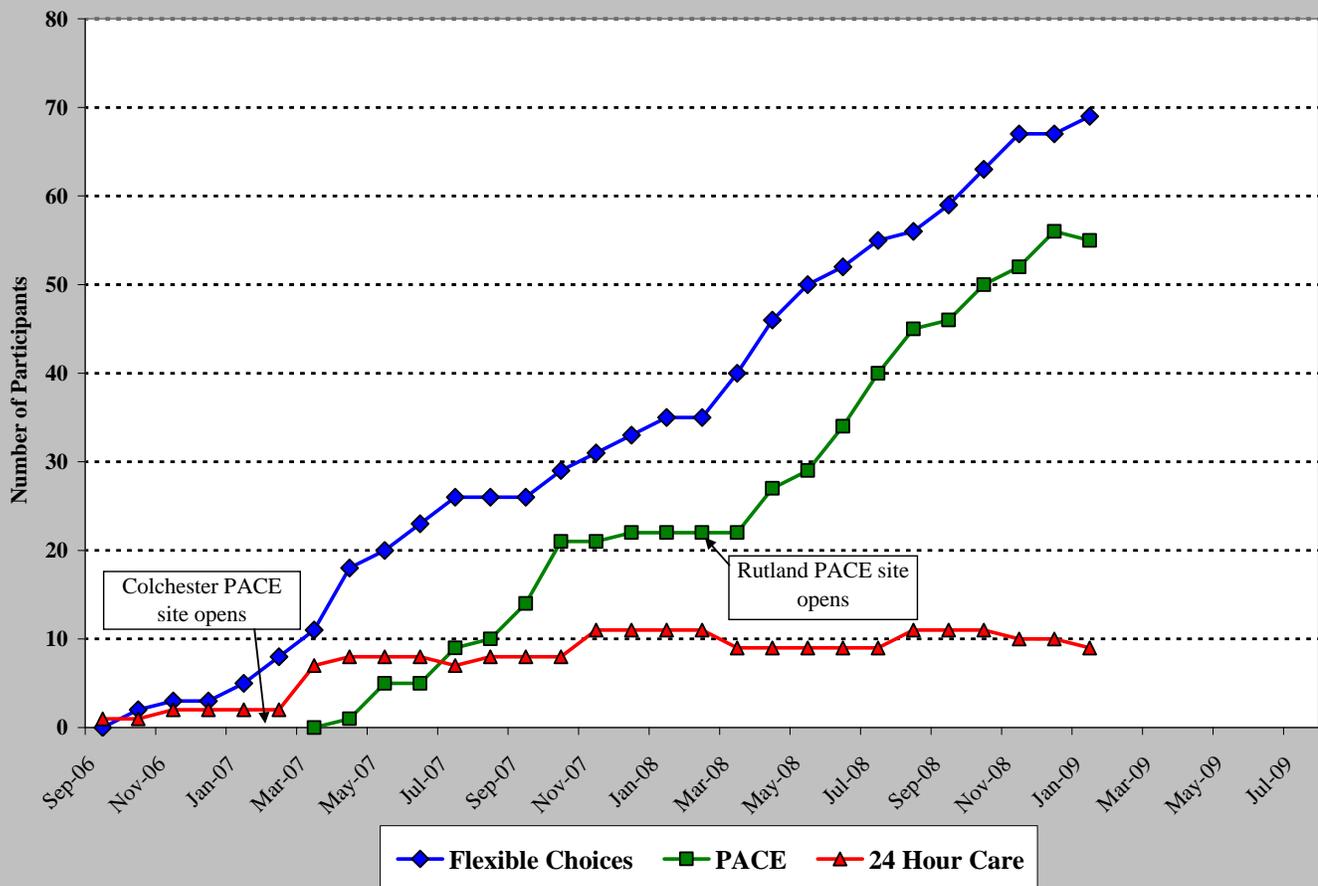
Data source: DRS, monthly provider reports

This shows ‘standardized’ nursing home days, in which the number of days of service each month is standardized for a constant 31-day month.

The number of people in Vermont nursing homes with Medicaid as primary payor has decreased by about 200 since October 2005, from about 2,170 to about 1,970. In 2008 the annual seasonal increase in Medicaid nursing home residents that tends to occur in July-November was higher than in 2007, but lower than in 2006.

The number of people who pay privately has also decreased, from about 510 people to about 440 people. The number of people served through Medicare increased from about 360 people to about 430 people.

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

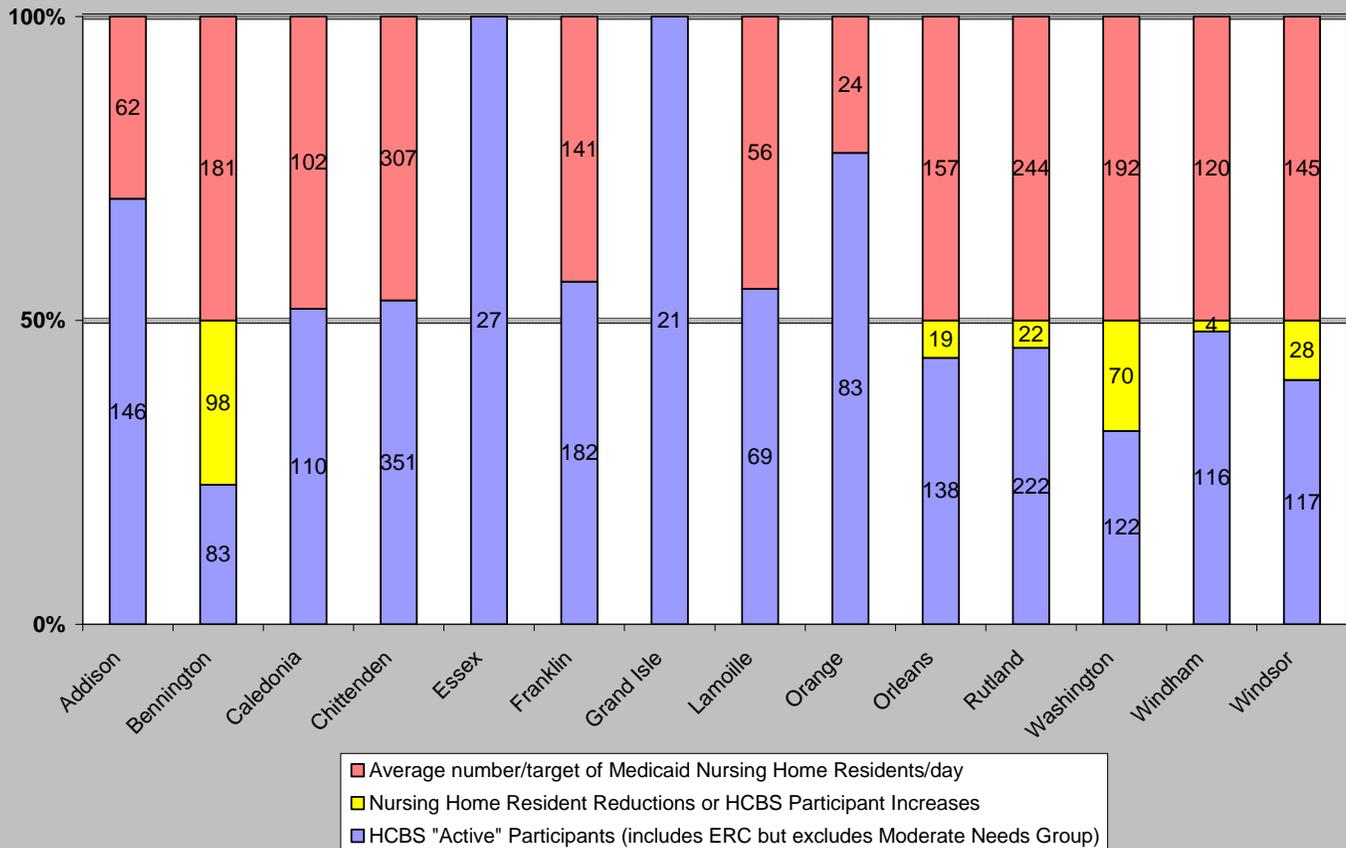


Data source: DAIL/DDAS SAMS database

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 HBS 24-Hour Care. Each represents a different service model, drawing people with different needs 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 availability of a spouse who is 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.

Vermont Choices for Care: Nursing Home Residents and Home & Community-Based Participants by County --January 2009
Changes (Yellow) Needed to Achieve At Least 50% HCBS



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

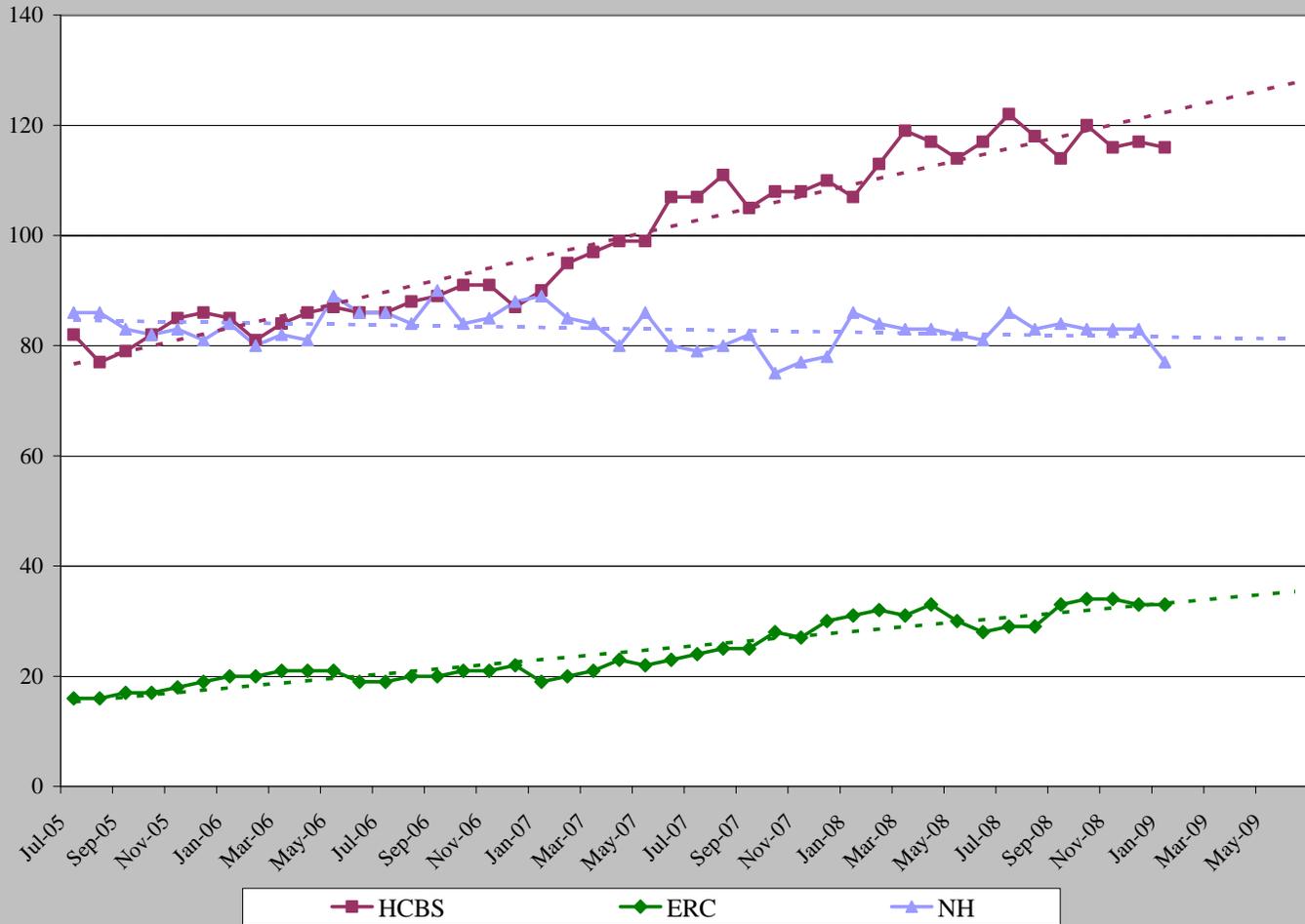
One of the expected outcomes of Choices for Care is that a higher percentage of people who use Medicaid-funded long term care will choose home and community-based settings, while a lower percentage will choose nursing homes. This graph illustrates the relative use of nursing homes and other settings in each county as of January 2009.

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.

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

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

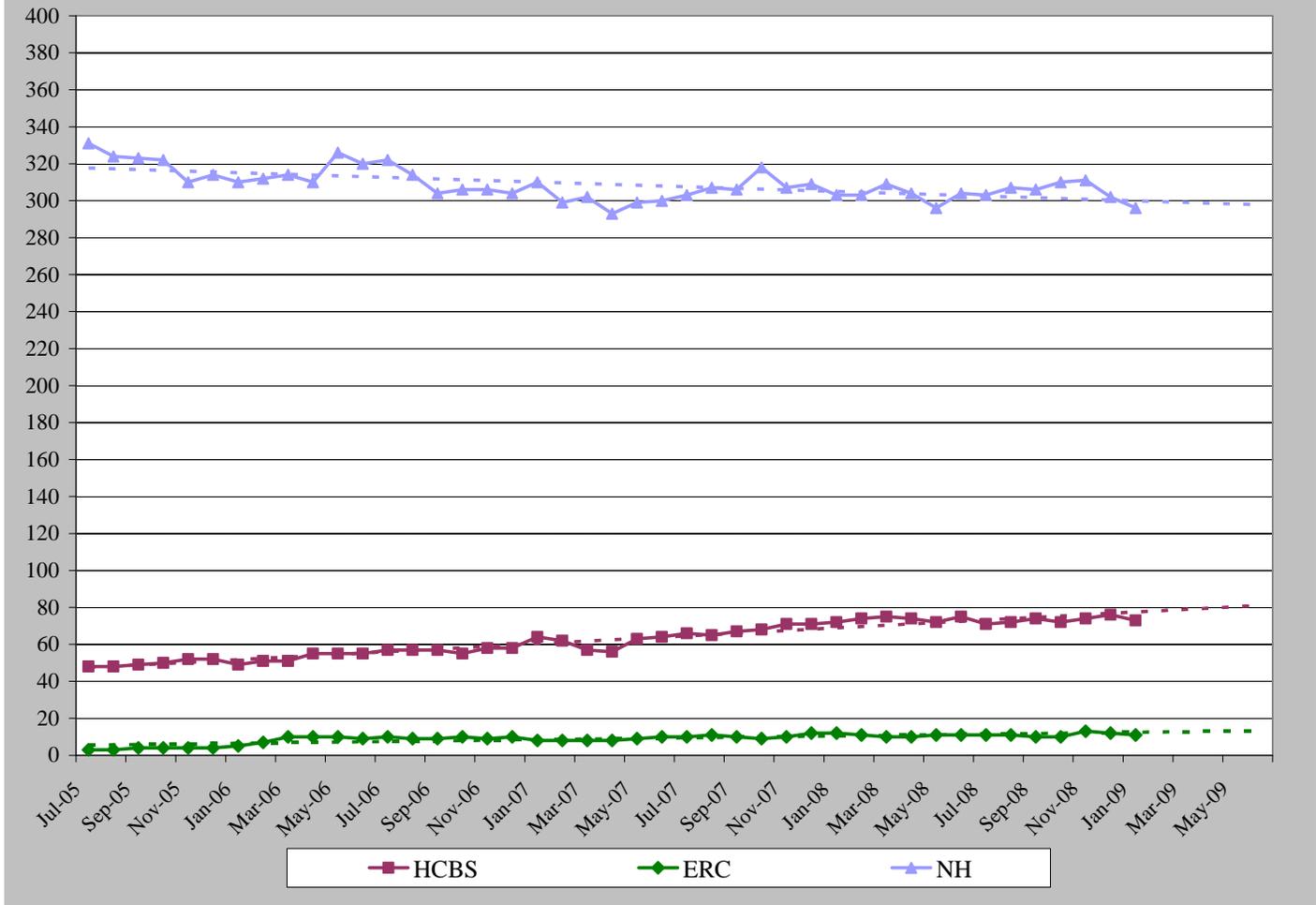


Data source: EDS paid claims

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

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

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

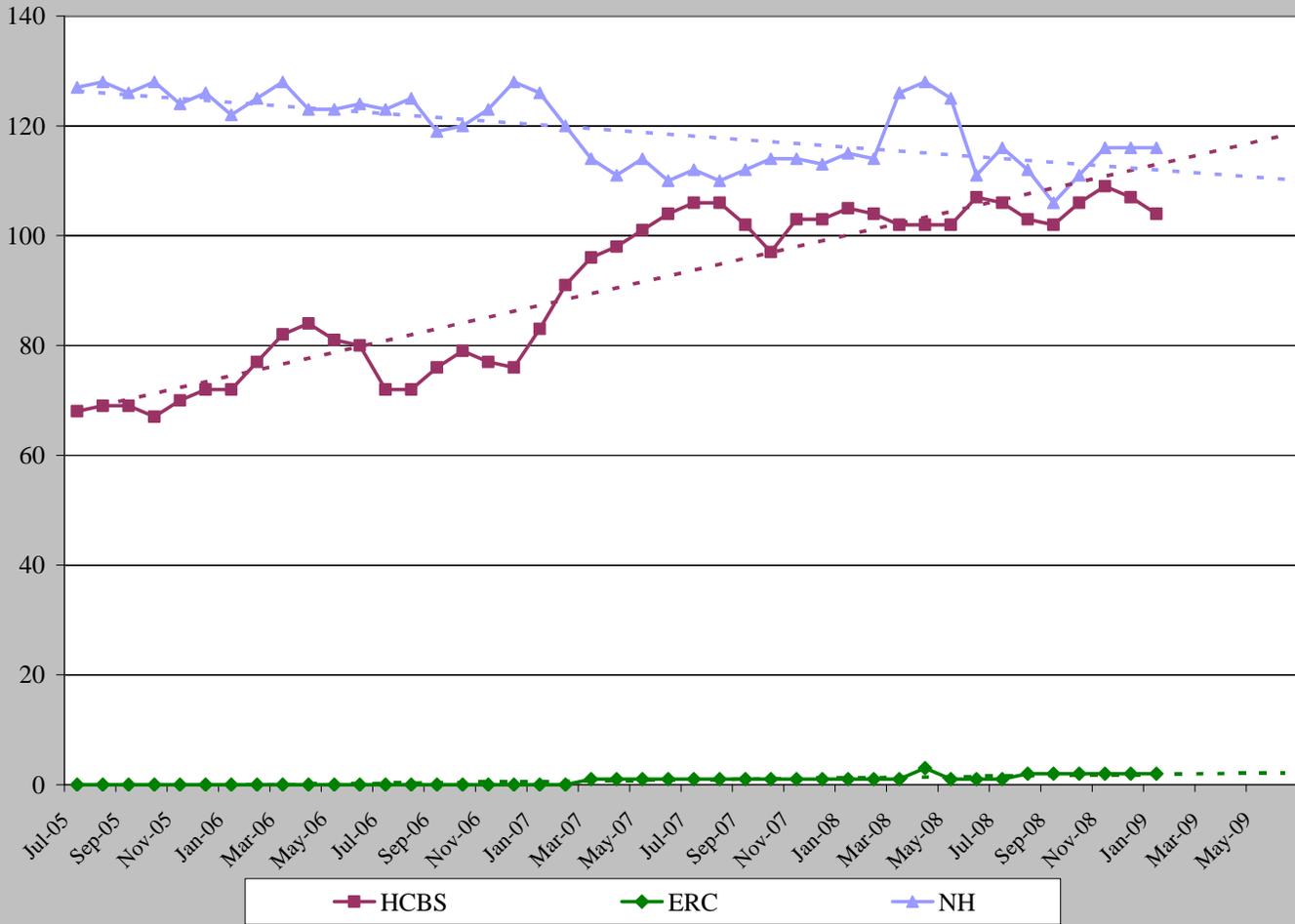


Data source: EDS paid claims

In Bennington County, use of both HCBS and ERC has very slowly increased since July 2005. The use of nursing homes has slowly decreased. This is the intended 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

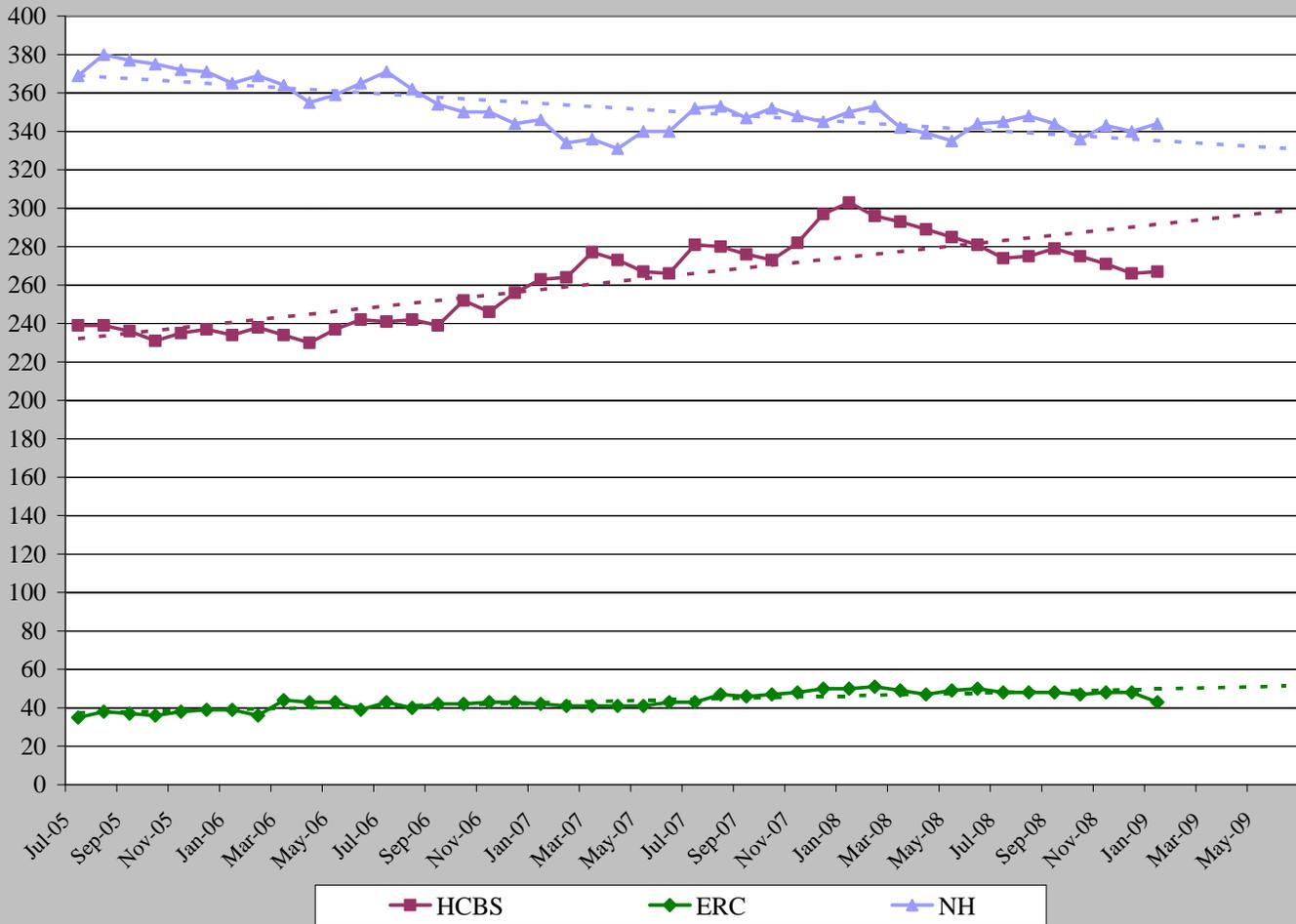


Data source: EDS paid claims

In Caledonia County, use of HCBS has increased significantly since July 2005, and the use of ERC has increased slightly. The use of nursing homes has decreased. This is the intended 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

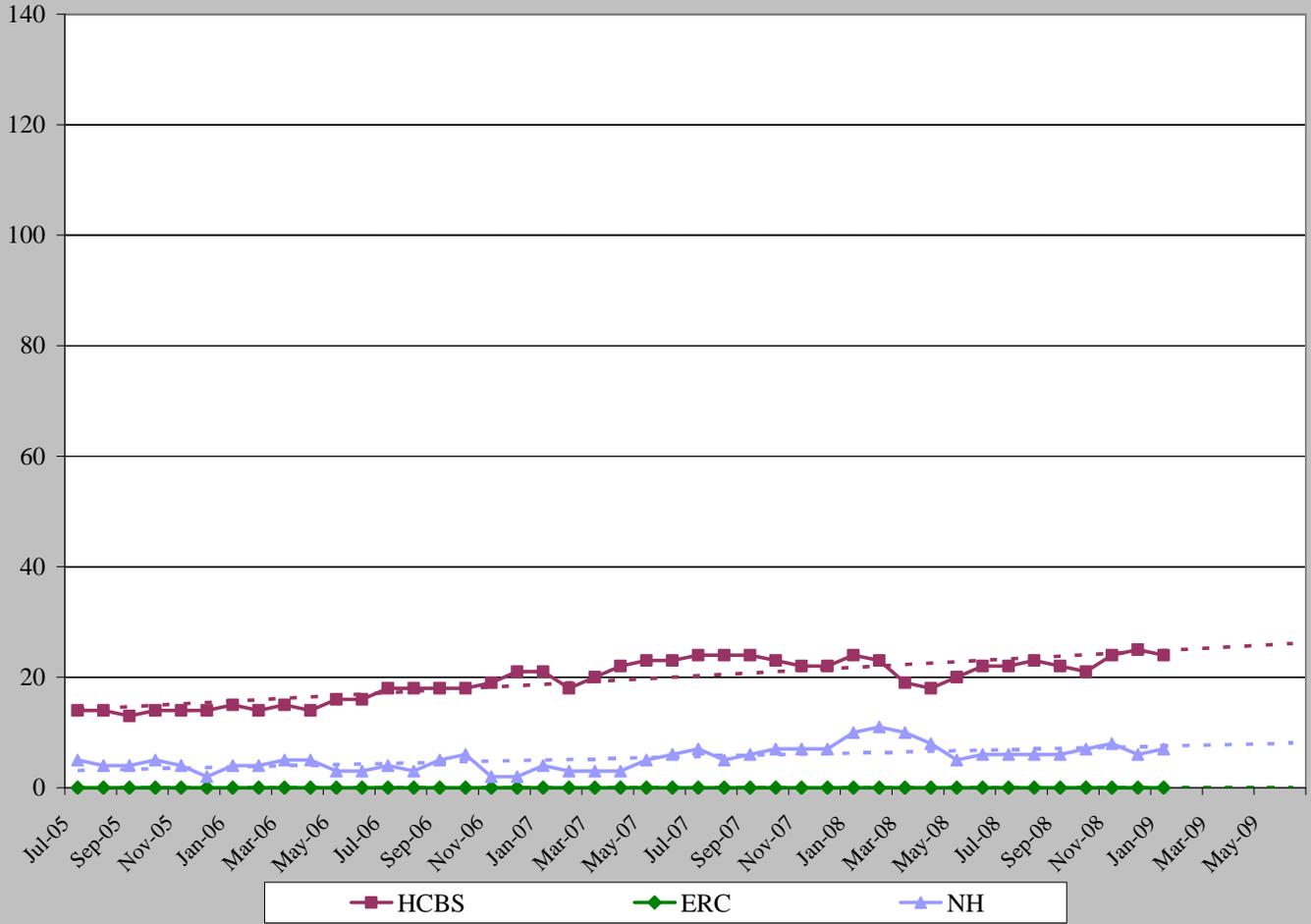


Data source: EDS paid claims

In Chittenden County, use of both HCBS and ERC has increased since July 2005. The use of nursing homes has decreased. This is the intended 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

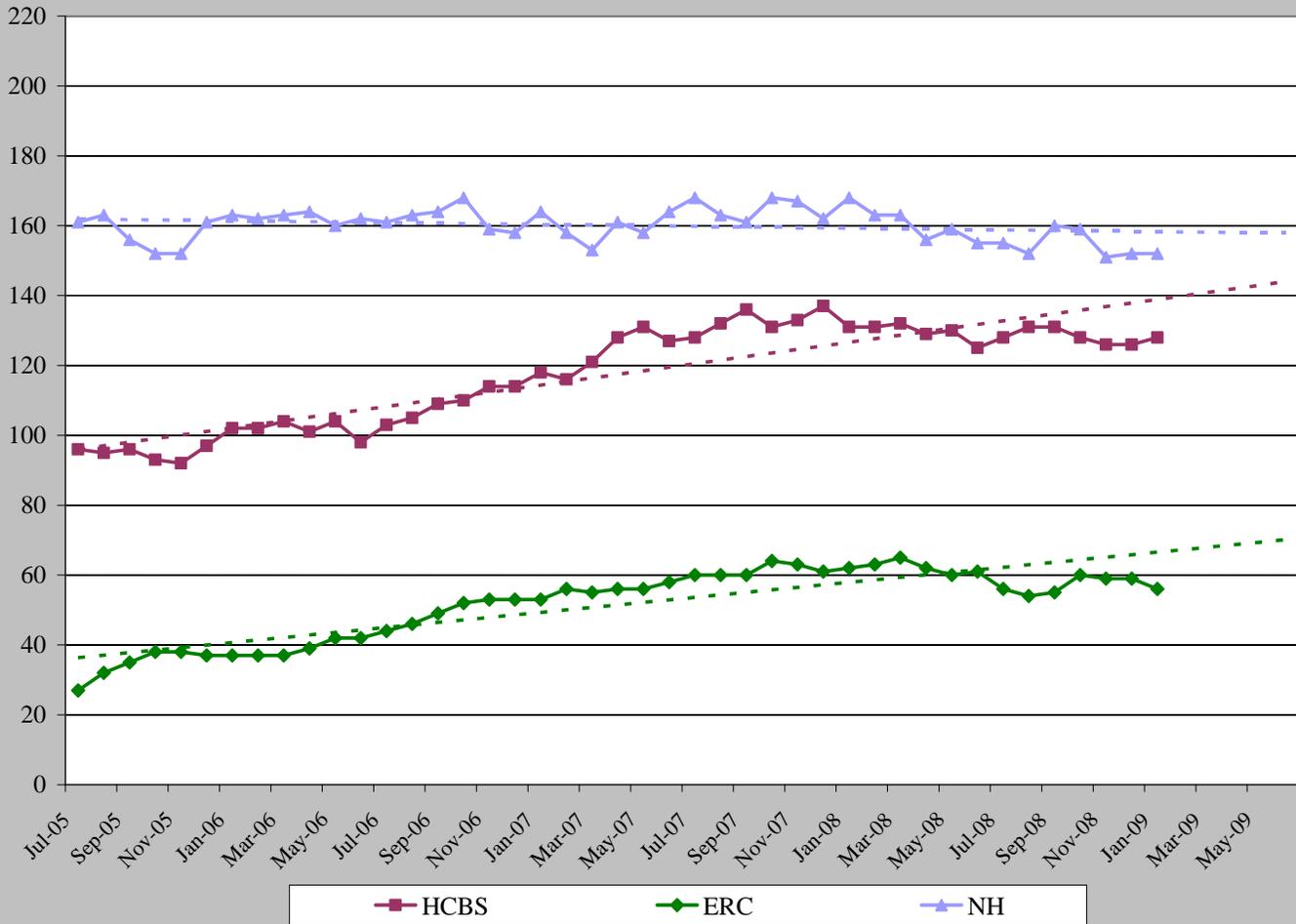


Data source: EDS paid claims

In Essex County, use of HCBS has increased since July 2005. The use of nursing homes has also increased. This is not the intended 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

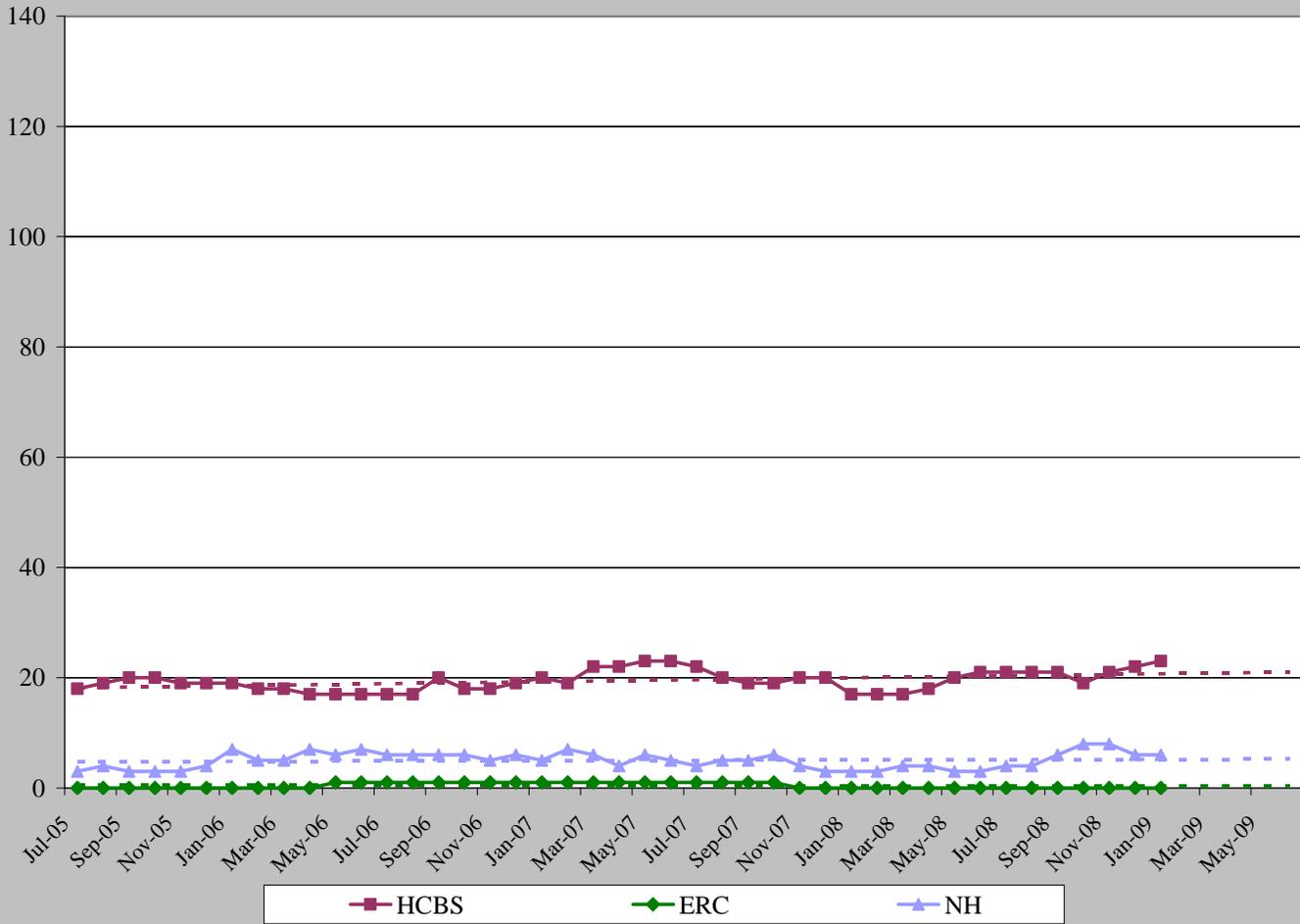


Data source: EDS paid claims

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

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

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

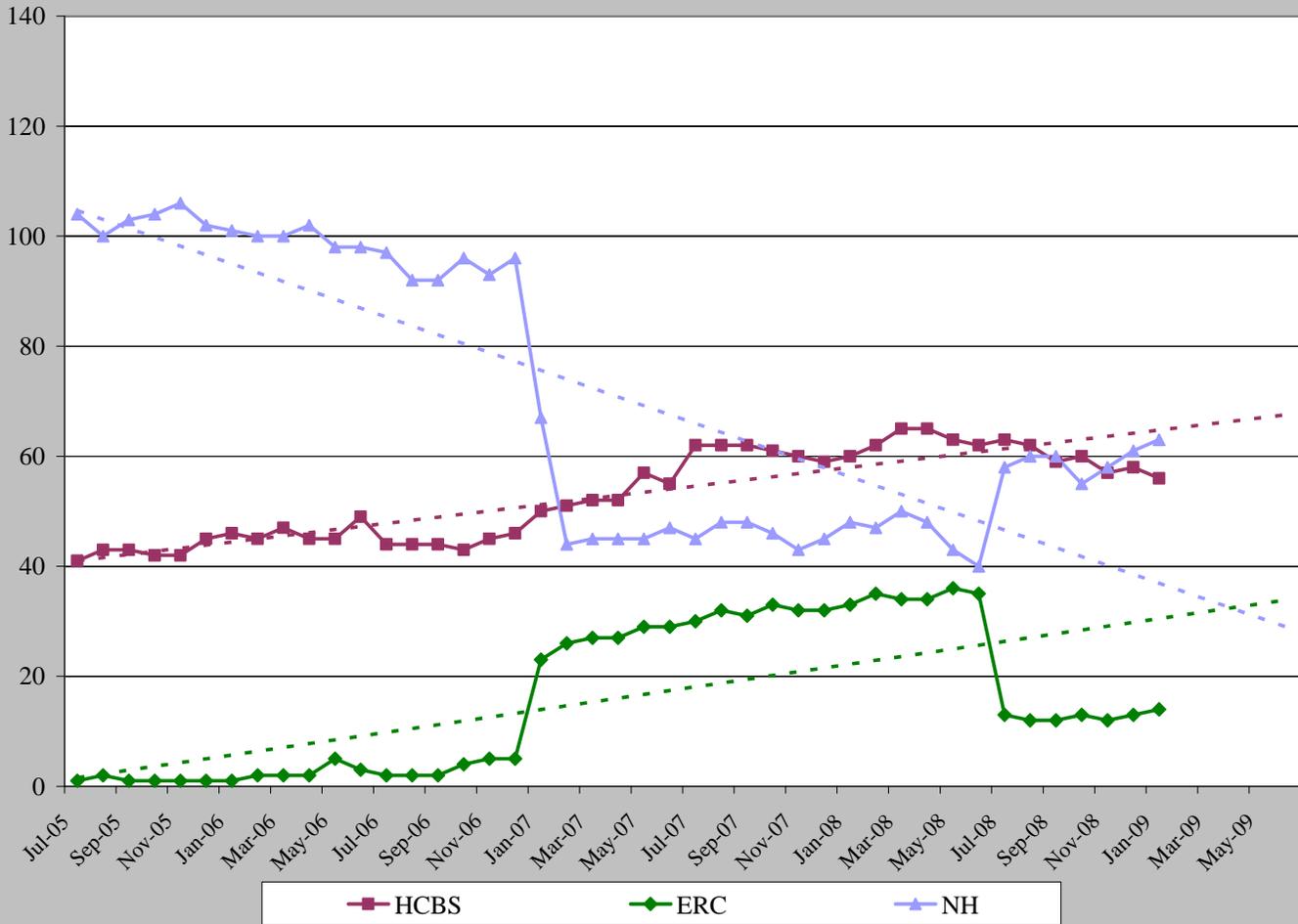


Data source: EDS paid claims

In Grand Isle County, use of HCBS has remained roughly stable since July 2005. The use of nursing homes has increased slightly. This is not the intended outcome of Choices for Care.

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

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

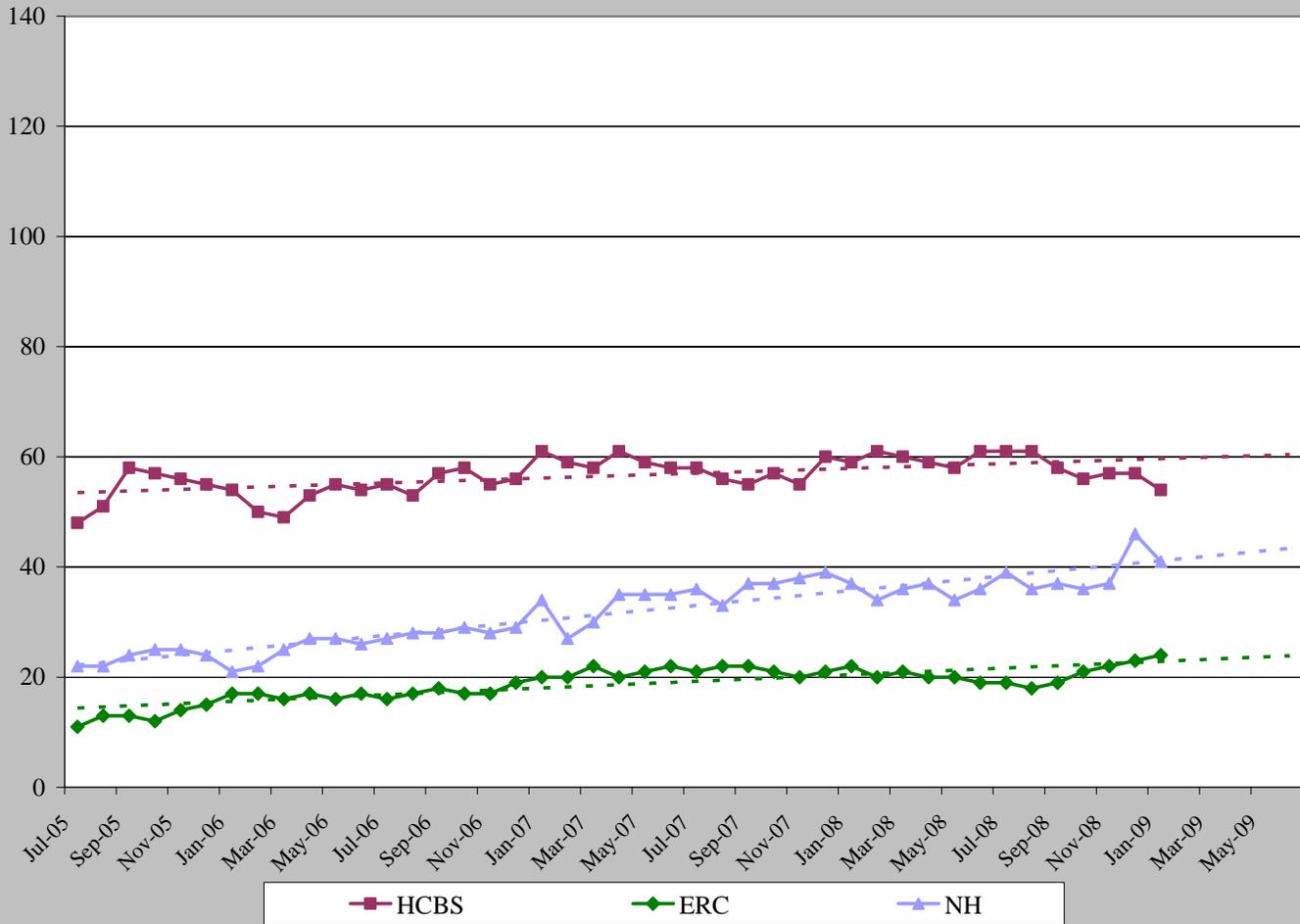


Data source: EDS paid claims

In Lamoille County, use of both HCBS and ERC has increased since July 2005. The use of nursing homes has decreased. This is the intended 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

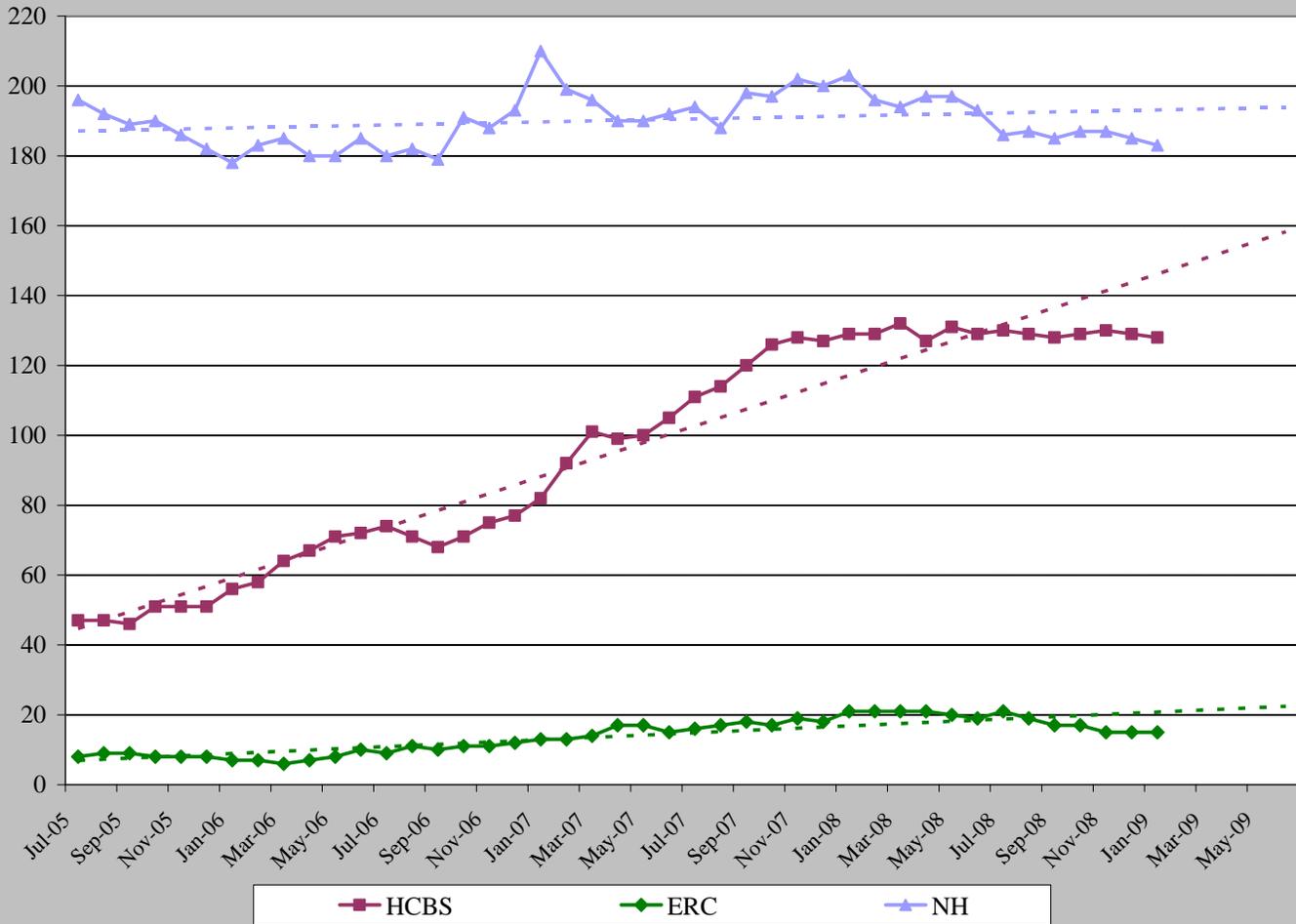


Data source: EDS paid claims

In Orange County, use of both HCBS and ERC has increased since July 2005. The use of nursing homes has increased at a faster rate. This is not the intended outcome of Choices for Care.

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

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

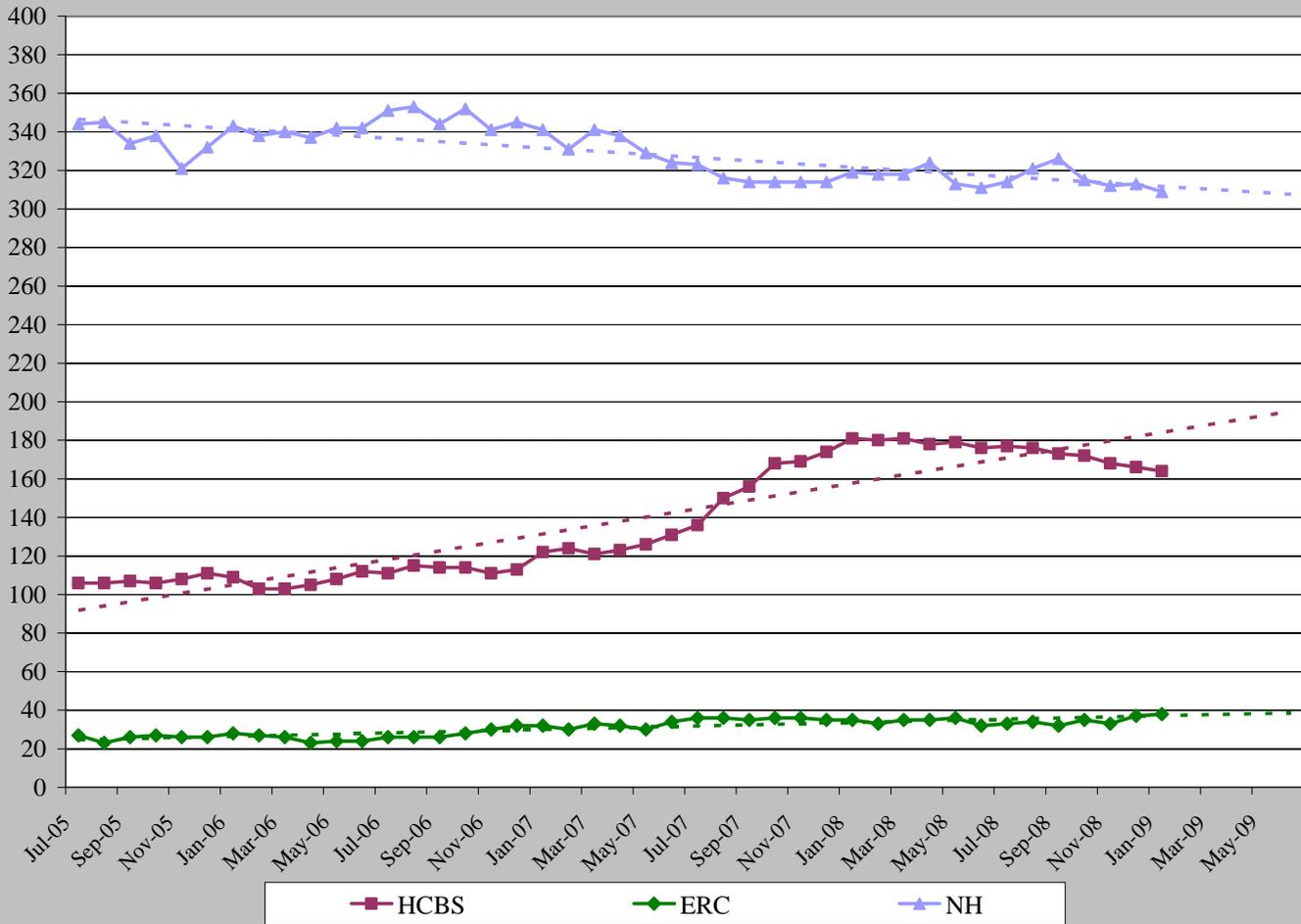


Data source: EDS paid claims

In Orleans County, use of HCBS has increased significantly since July 2005, and the use of ERC has increased slightly. The use of nursing homes has remained roughly stable. This is not the intended 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

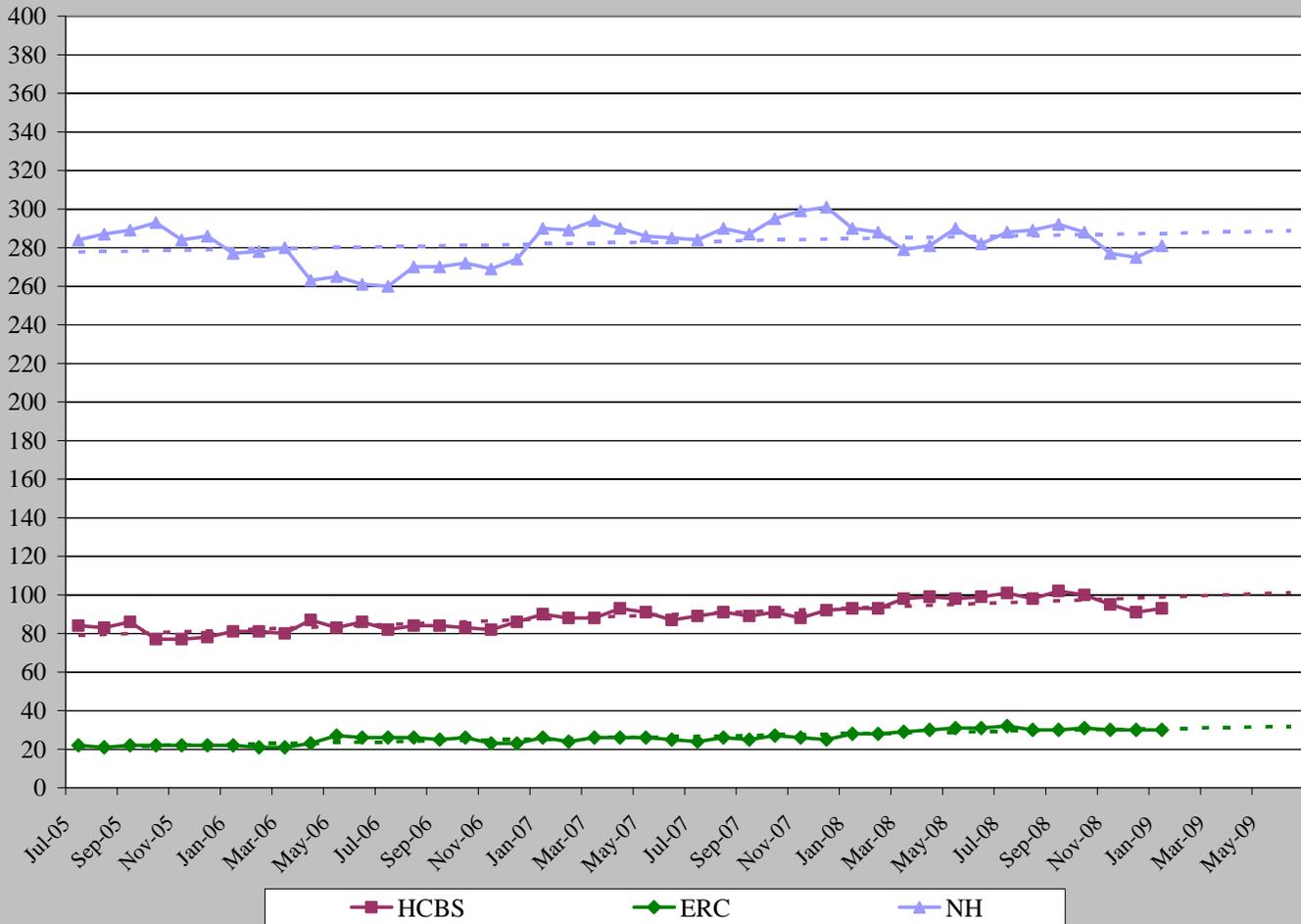


Data source: EDS paid claims

In Rutland County, use of HCBS has increased significantly since July 2005, and the use of ERC has increased slightly. The use of nursing homes has decreased modestly. This is the intended 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

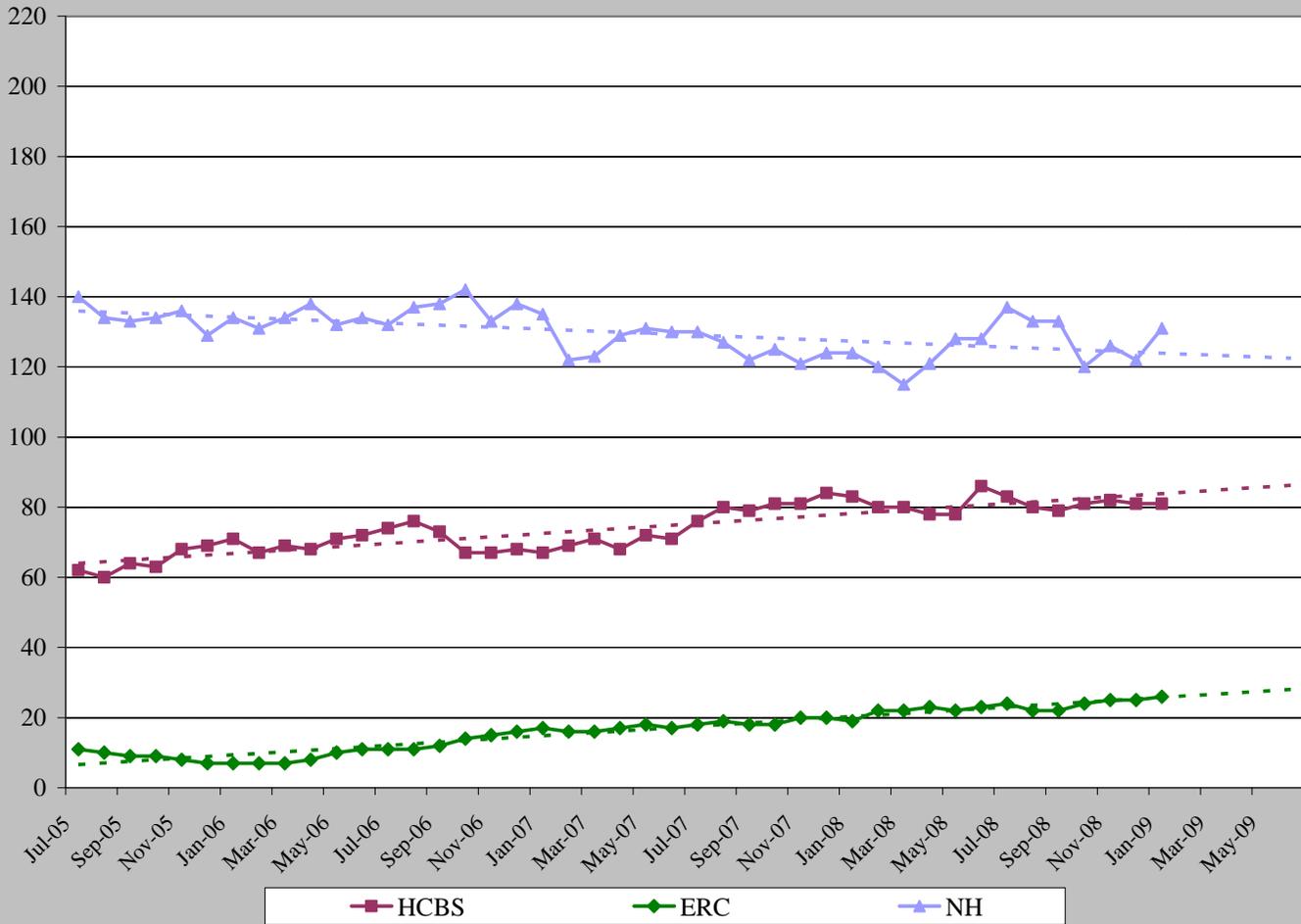


Data source: EDS paid claims

In Washington County, use of HCBS and ERC has increased slightly since July 2005. The use of nursing homes has also increased. This is not the intended outcome of Choices for Care.

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

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

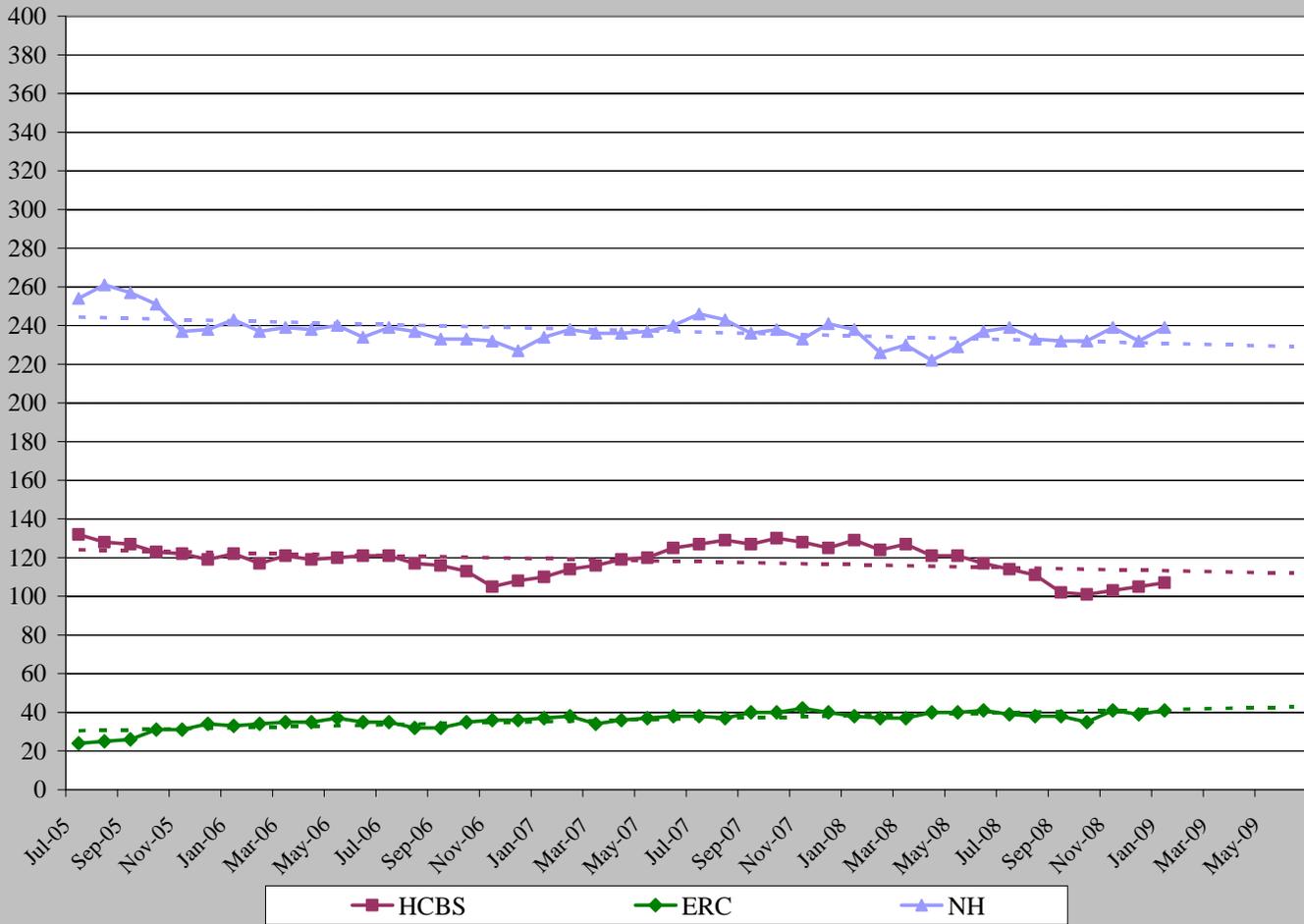


Data source: EDS paid claims

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

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

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

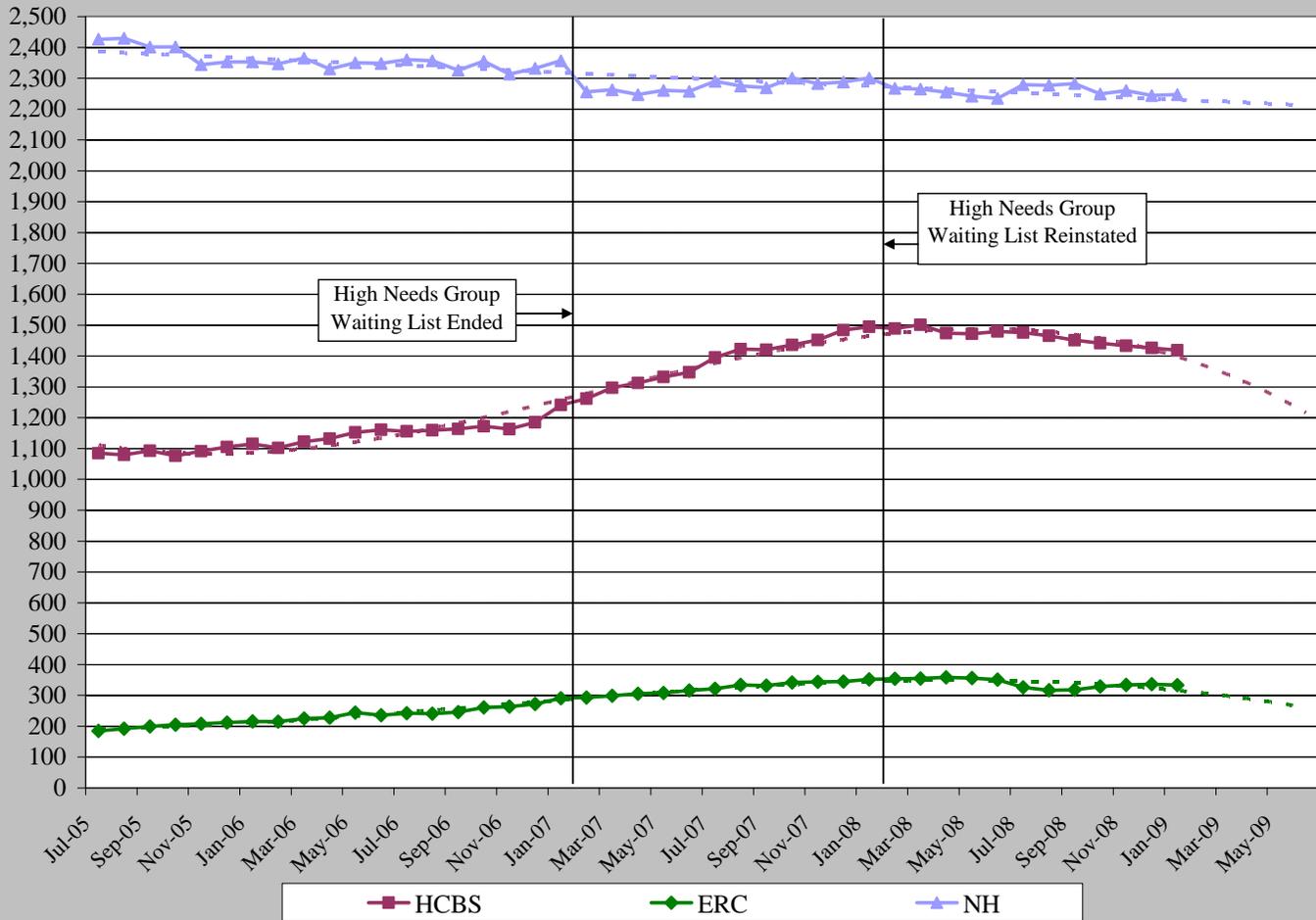


Data source: EDS paid claims

In Windsor County, use of HCBS has decreased since July 2005, and the use of ERC has increased slightly. The use of nursing homes has decreased slightly. This may not reflect the intended outcome of Choices for Care.

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

In Vermont as a whole, use of HCBS has increased significantly since July 2005. The use of ERC has increased, and the use of nursing homes has decreased. This is the intended outcome of Choices for Care.