



# **Choices for Care**

## **Quarterly Data Report**

### **July 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.**

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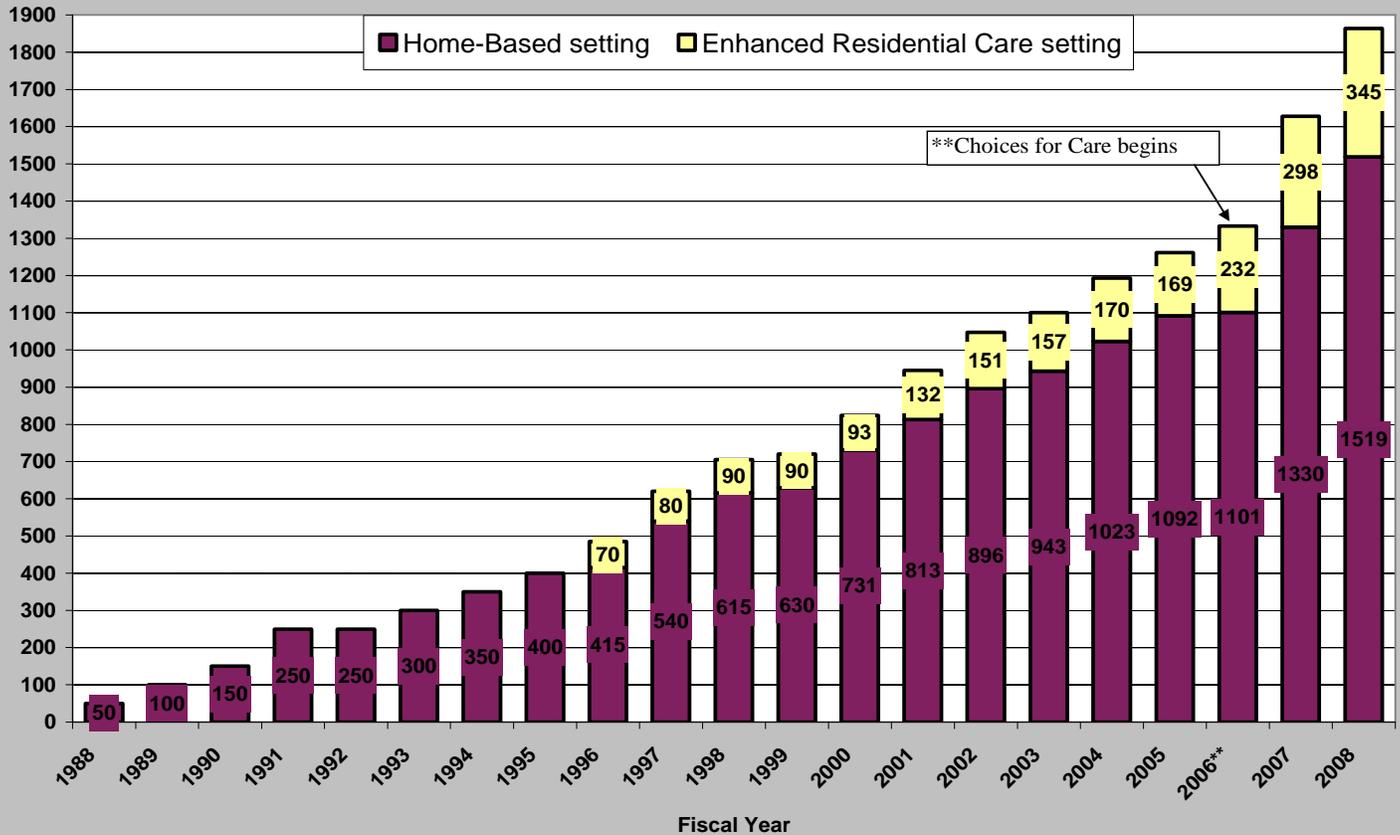
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## Numbers of People Served in Aged/Disabled Medicaid Waivers Maximum Point-in-Time by Year, sfy1988-sfy2008

*(does not include moderate needs group)*



Data source: DAIL/DDAS databases

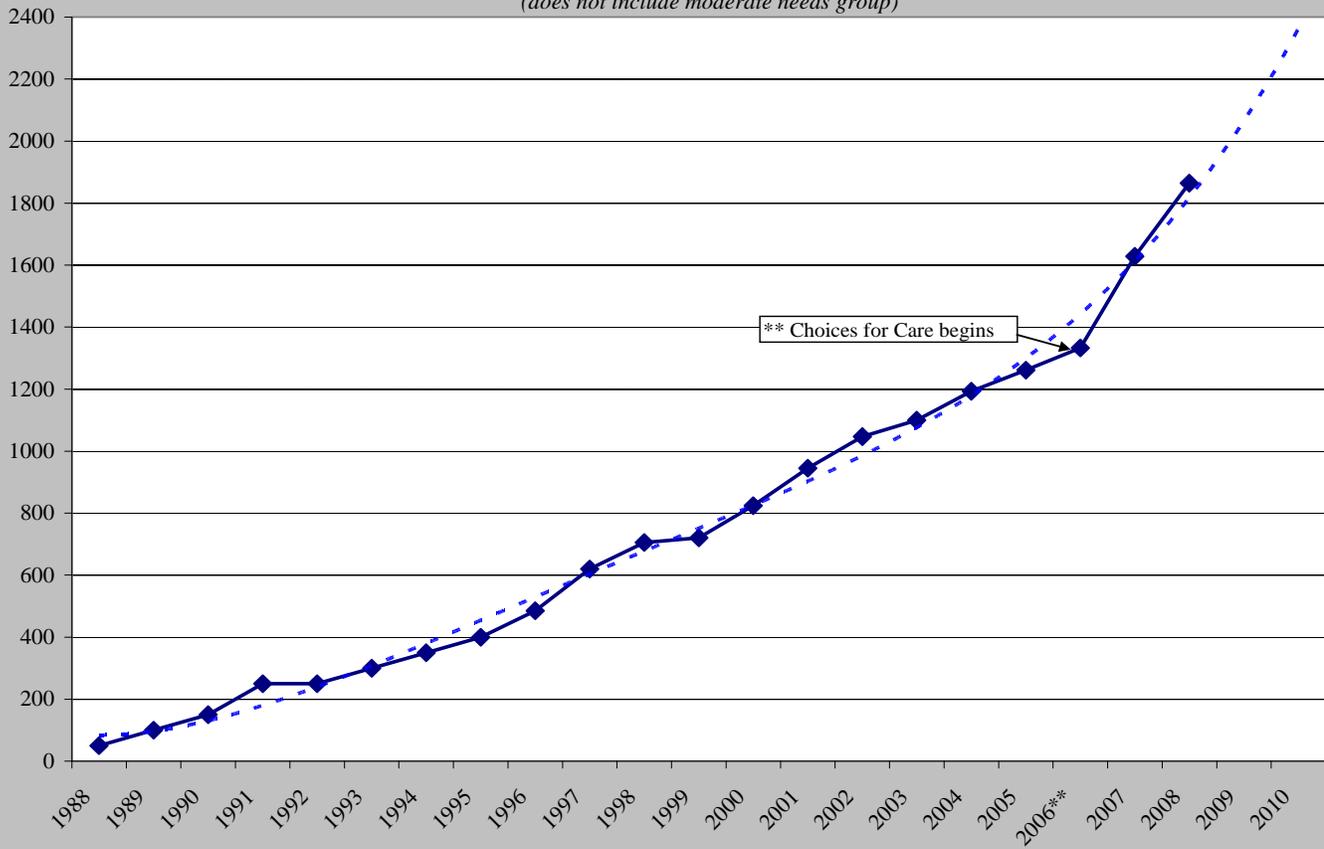
This graph illustrates the growth in home and community based services in Vermont since SFY1988.

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. This increase in the number of people served is significantly higher than before 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

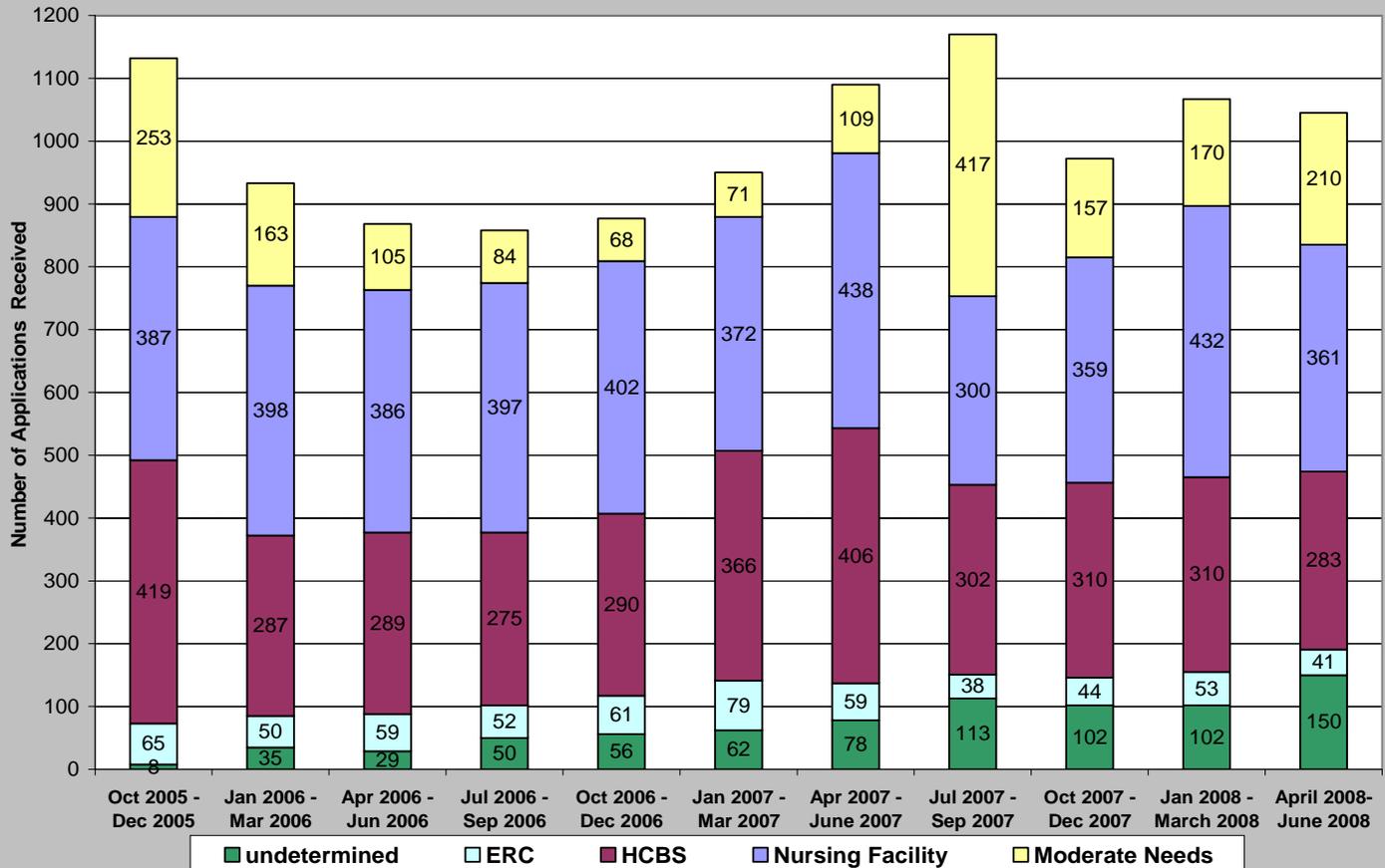
*(does not include moderate needs group)*



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 July 1, 2008**



Data source: DAIL/DDAS SAMS database.

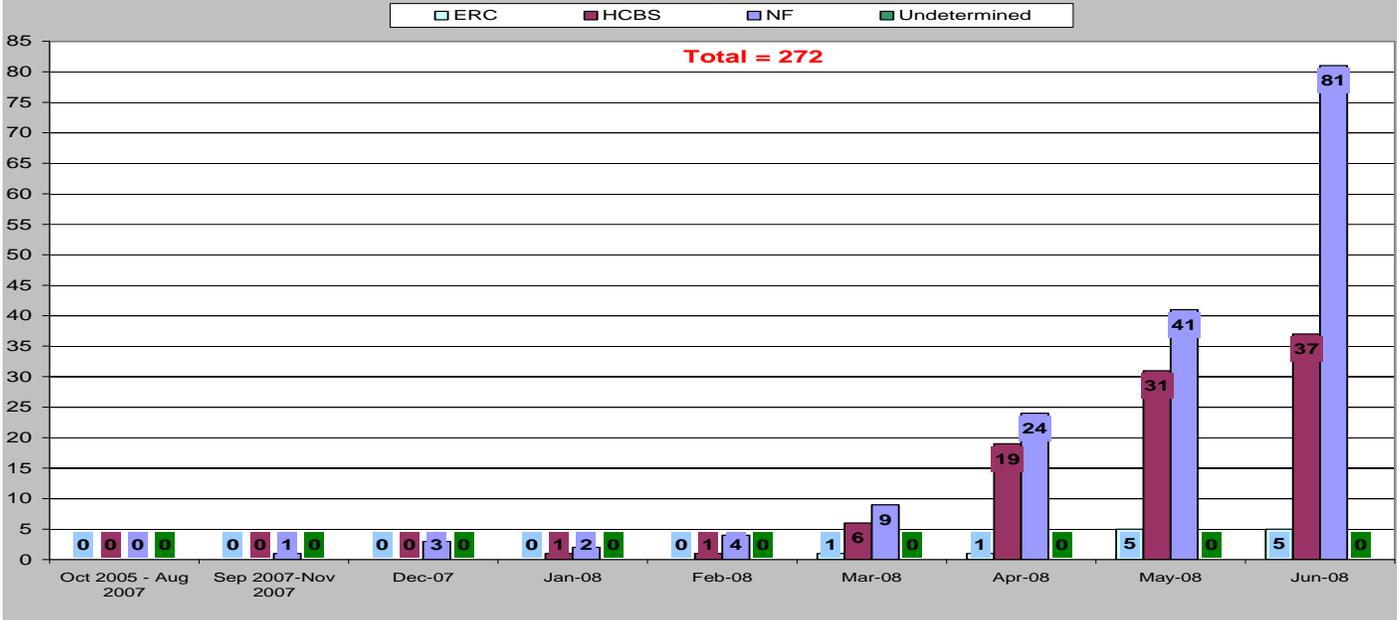
Since October 2005, DAIL staff have processed an average of about 325 applications per month.

The number of applications has increased in the past year, partly due to increased funding for the Moderate Needs Group. In SFY2006 (three quarters), DAIL staff received about 2900 applications, or about 325 per month. In SFY2007, DAIL staff received about 3800 applications, or about 315 per month. In SFY2008, DAIL staff received about 4250 applications, or about 355 per month.

Applicants requested these service settings on their applications:

- NF: 39%
- HCBS: 32%
- MNG: 16%
- ERC: 5%
- Undetermined: 7%

**Choices for Care: Applications 'Pending Medicaid' by Status Date  
October 2005 through June 2008  
as of July 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 in achieving this goal 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 some progress.

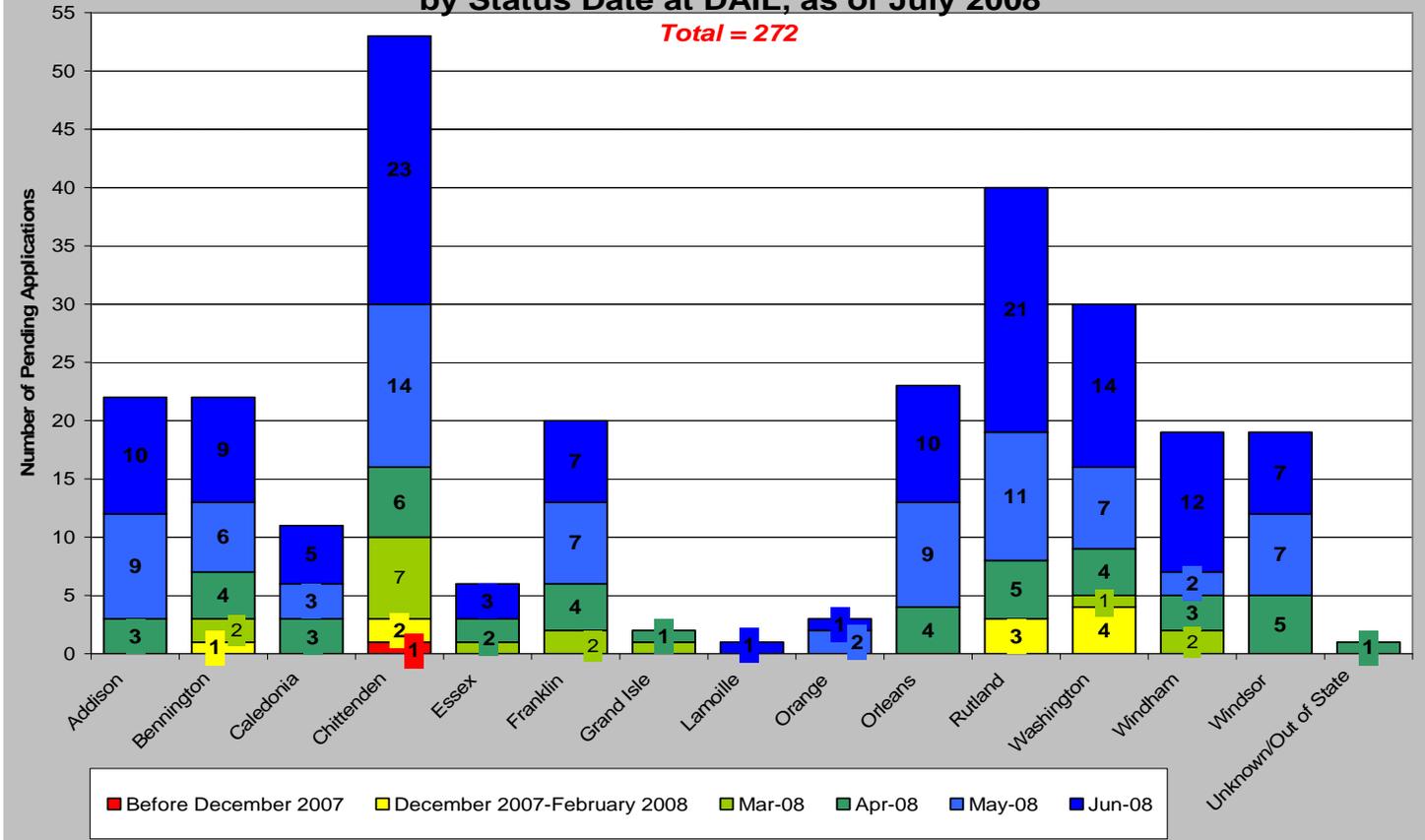
In May 2008 the independent evaluators for the Vermont Aging and Disability Resource Centers project (Flint Springs Associates) examined sample baseline data to determine how long the Choices for Care clinical and financial eligibility determination processes take. On average:

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.

Similar to the Flint Springs Associates findings, SAMS data shows that more than half of all pending applications had been awaiting LTC Medicaid financial decisions for more than a month:

|            |     |     |
|------------|-----|-----|
| < 30 days  | 123 | 45% |
| 31-60 days | 77  | 28% |
| 61-90 days | 45  | 17% |
| > 90 days  | 27  | 10% |

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



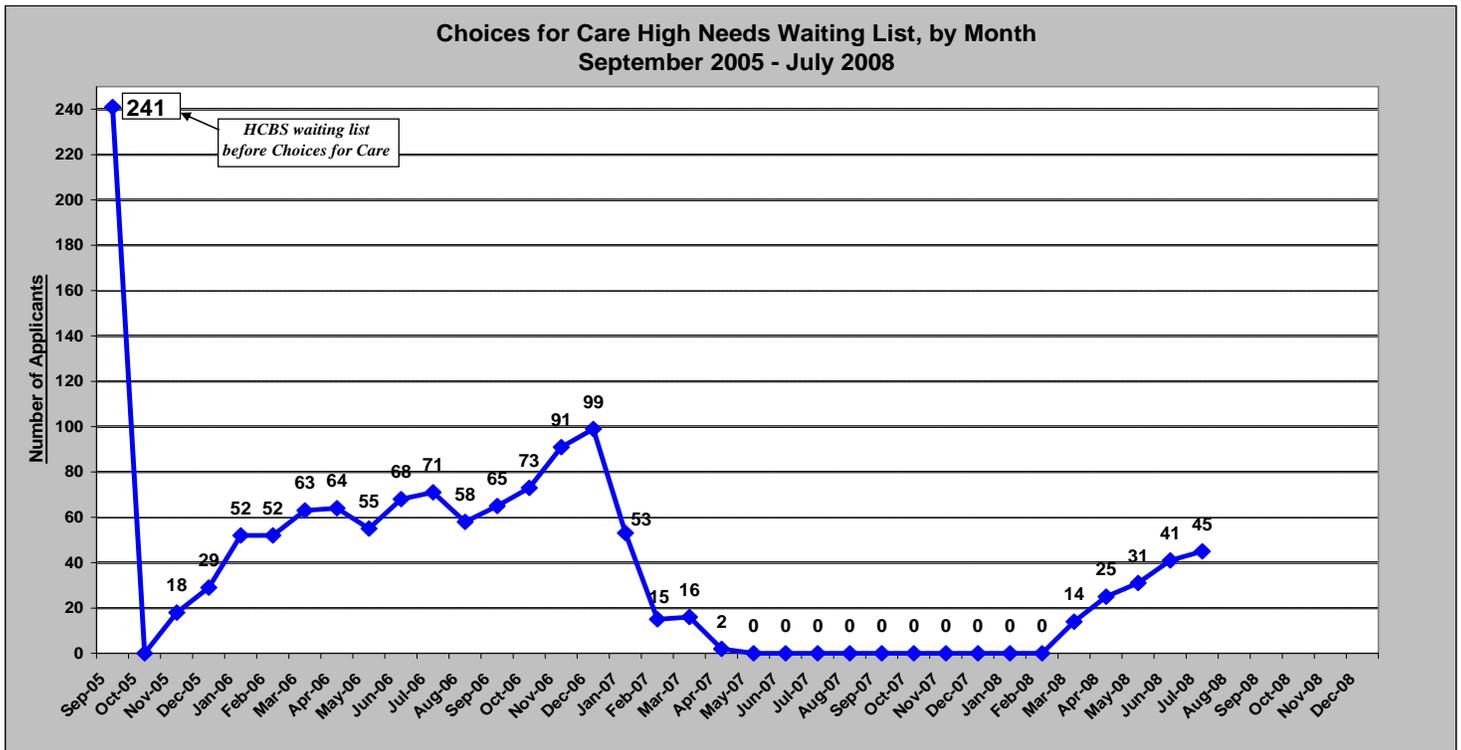
Data source: DAIL/DDAS SAMS database.

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. Bennington, Essex, and Grand Isle counties had relatively high percentages of applications pending more than 90 days.

These findings suggest that timely access is a problem for some applicants. In the short term, effective communication and collaboration between DAIL regional staff, DCF regional staff, and local case managers contribute to the timely processing of applications. In the longer term, state staff are working to integrate the DAIL and DCF information systems and business processes, using new information systems.

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. Unfortunately, waiting lists for home and community-based services are common across the United States:

*Despite mounting demand for expanded Medicaid HCBS, all states reported using cost controls on HCBS waivers in 2006, such as restrictive financial and function eligibility standards, enrollment limits, and waiting lists. In 2006, 280,176 individuals were on waiting lists for 93 waivers in 31 states, up from 260,916 individual in 2005 and 206,427 individuals in 2004. The average length of time an individual spent on a waiting list ranged from 13 months for aged/disabled and children’s waivers to 42 months for aged waivers. Compared to the previous year, the number of individuals on waiver waiting lists increased by more than 7 percent, with the growth evenly distributed among the various target groups.*

*Kaiser Commission on Medicaid and the Uninsured, Medicaid 1915(c) Home and Community-Based Service Programs: Data Update, December 2007 (<http://www.kff.org/medicaid/upload/7720.pdf>)*

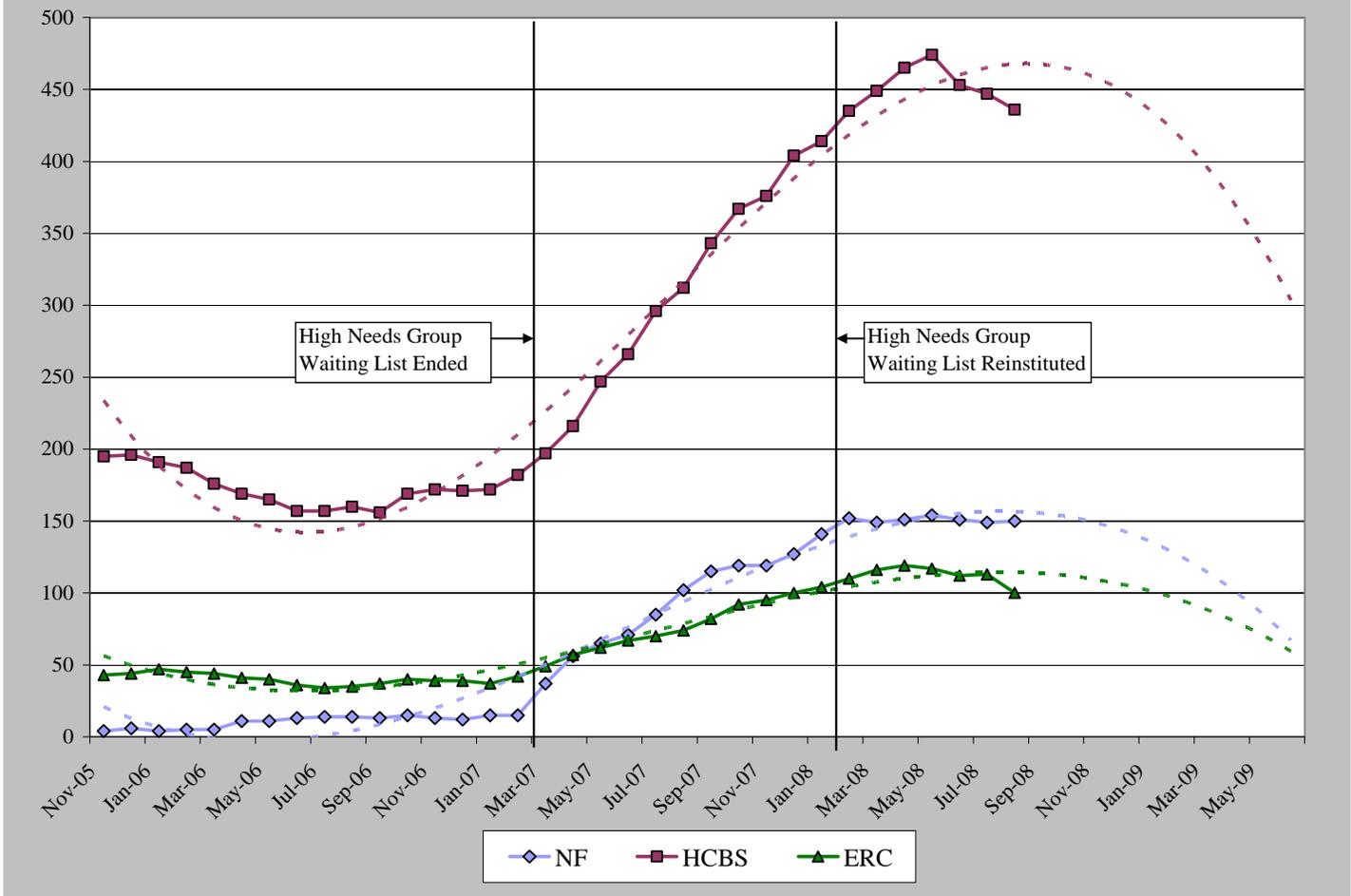
Prior to Choices for Care, many applicants for HCBS and ERC were placed on waiting lists. The total number of people on waiting lists fell when Choices for Care was implemented in October 2005, when all applicants who meet Highest Needs Group eligibility criteria became entitled to services.

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 expenditures exceed revenues. The Choices for Care waiting list is unique in the United States, 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.

Due to initial concerns about enrollment and expenditure trends 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, Choices for Care expenditure trends allowed all High Needs Group applicants to be enrolled, and the waiting list fell to zero. Due to recurring financial pressures, the high needs group waiting list was resurrected in February 2008.

Of the 45 people on the waiting list in July 2008, 42 people were waiting for services in the HCBS setting, 2 people were waiting for services in the ERC setting, and 1 person was waiting for services in the NF setting.

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



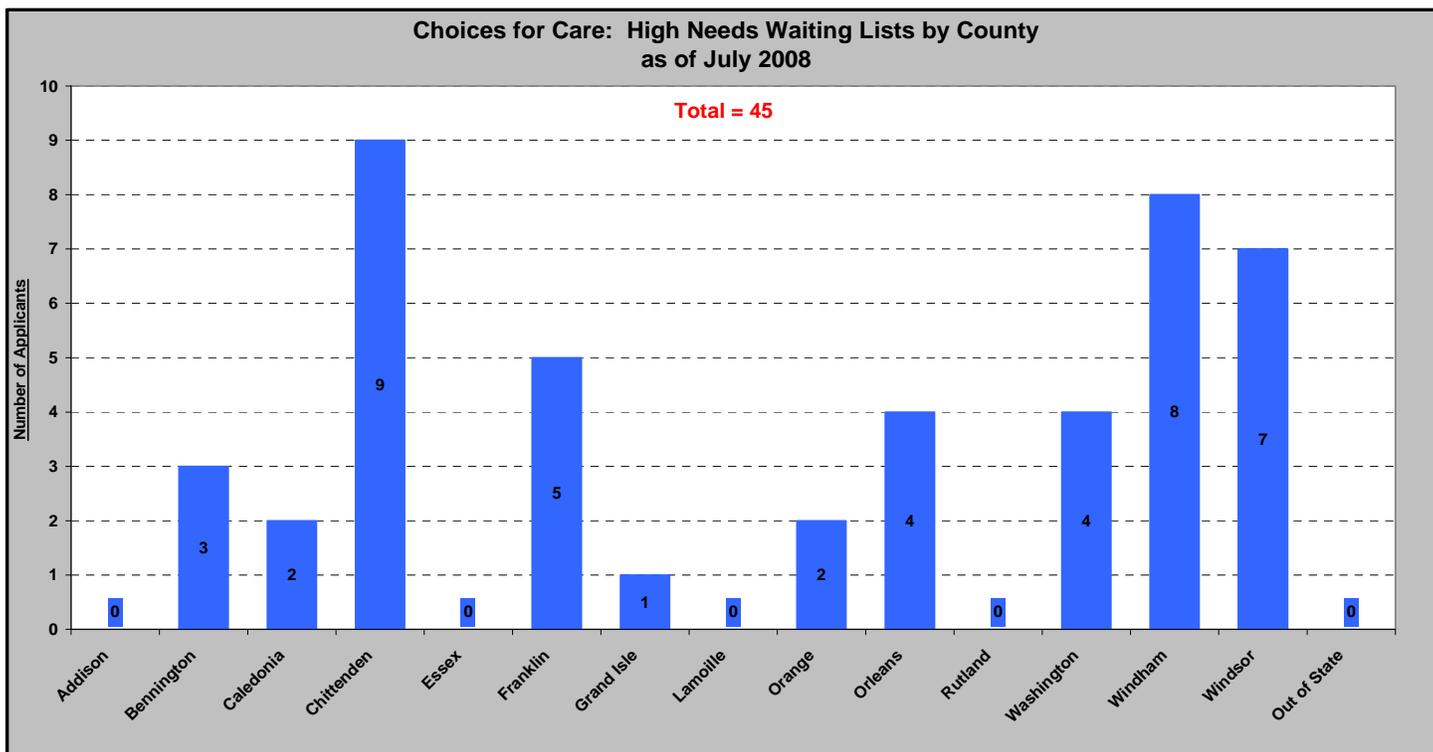
Data source: DAIL/DDAS SAMS database.

How has the waiting list affected enrollment in Choices for Care? This shows that 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 reinstated in February 2008, enrollment began to fall. Note that the decrease did not begin until several months had passed. This delay was caused by the length of time required for all eligibility processes to be completed.

The recent data suggests:

1. The High Needs Group waiting list will reduce enrollment, which will reduce expenses in SFY2009. This means that the waiting list can 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. Decisions that change CFC eligibility or services may not have a discernable effect for several months, and may not have a substantial effect 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. Between February 1, 2008 and July 28, 2008, 35 people have been enrolled under ‘special circumstances’, and 10 people in this group were pending Medicaid. Similar to the circumstances surrounding the previous high needs group waiting list, most people were served in the nursing home setting:

| High Needs Special Circumstances- Service Setting | Before Feb. 2008<br><i>by enrollment start date</i> |      | After Feb. 2008<br><i>includes pending Medicaid</i> |      |
|---|---|------|---|------|
|   | N   | %    | N   | %    |
| HCBS  | 42  | 26%  | 9   | 20%  |
| ERC   | 12  | 7%   | 4   | 9%   |
| NF  | 108   | 67%  | 32  | 71%  |
| Total   | 162   | 100% | 45  | 100% |

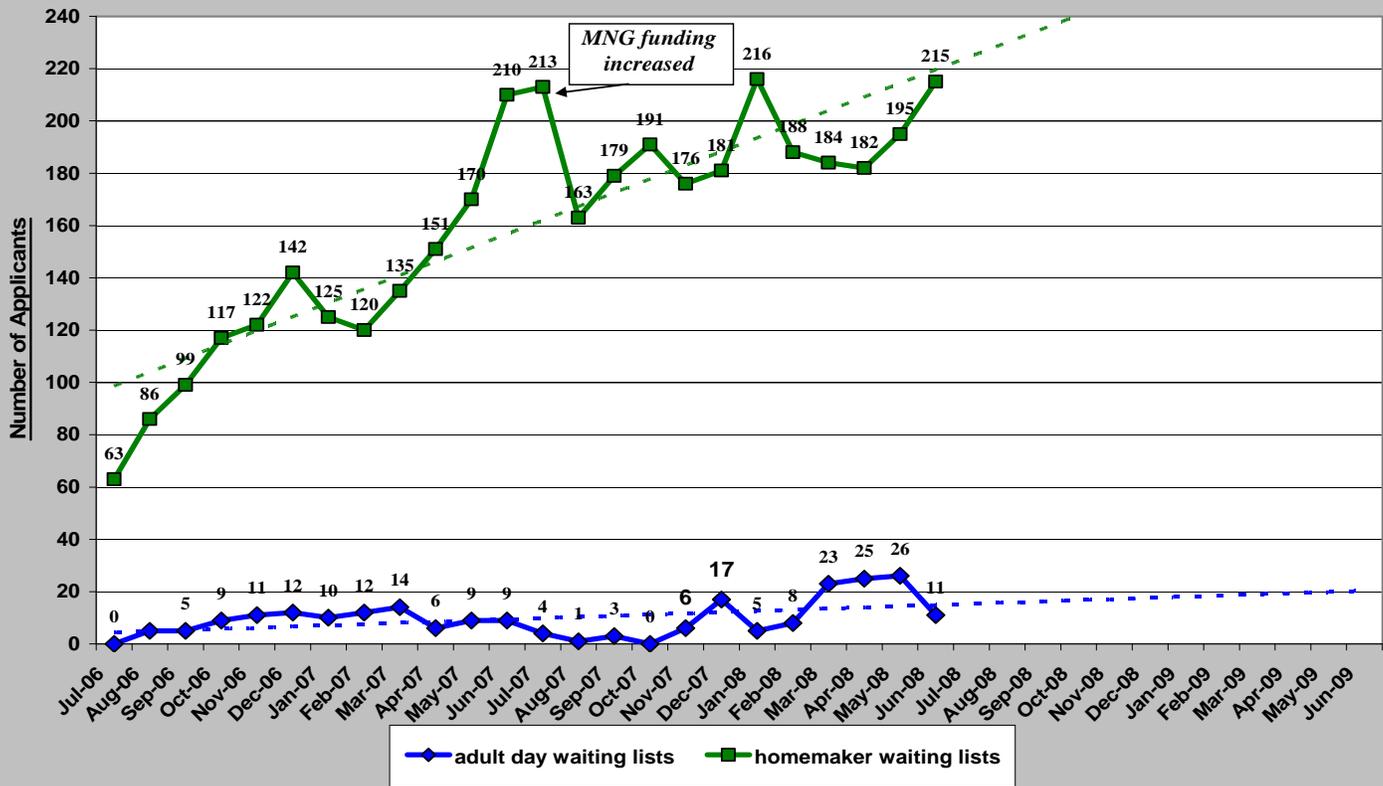
Because people’s needs can change, it is important that we monitor the status and situation of people who are on the waiting list. This is one important role of case managers, who stay in touch with applicants and can help people access other services. Case managers also help to identify people who should 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 by less than 10 people each month. About another 10 people were enrolled under special circumstances each month. Based on the previous trends, this seems to leave about 50 people unaccounted for each month. What happened to the hundreds of people who we would have expected to apply for CFC services as part of the high needs group, 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 care for 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



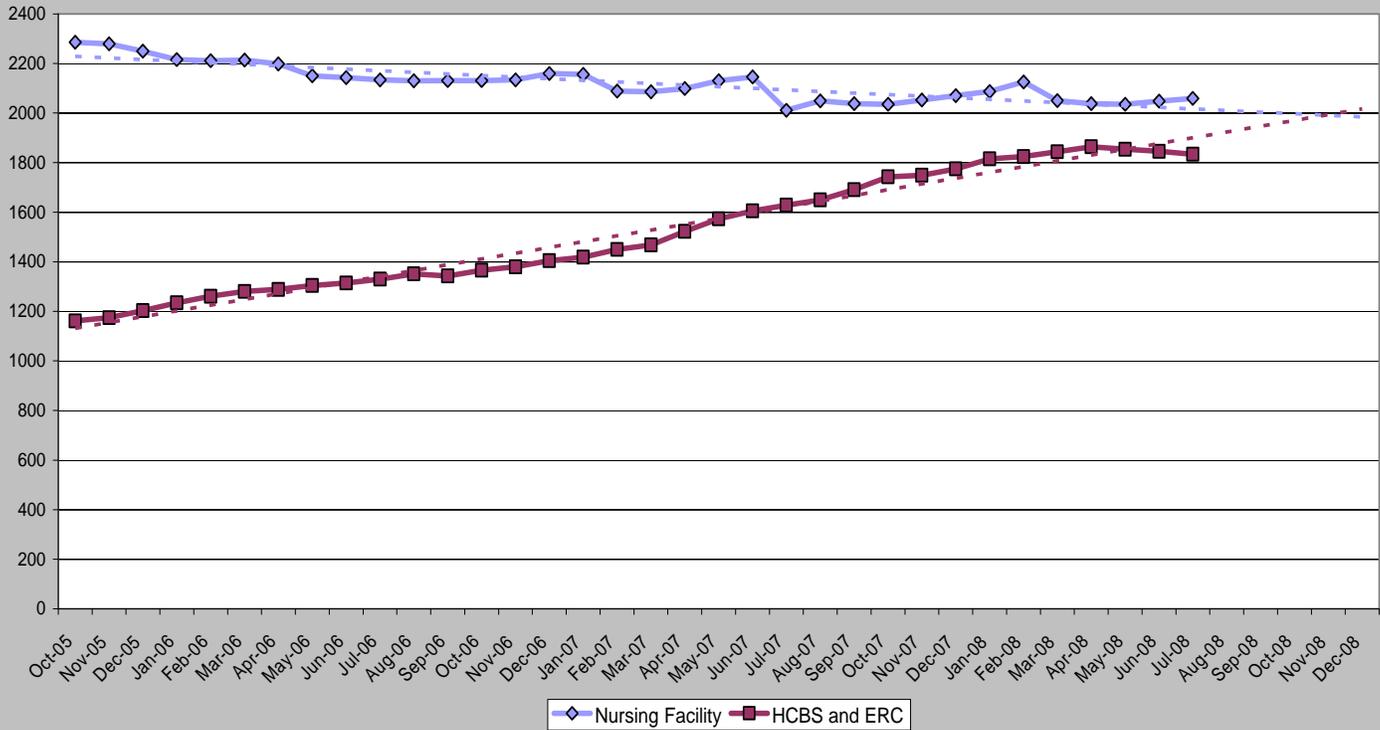
Data source: waiting list reports from home health agencies and adult day programs.

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 has increased significantly over time, and remains substantially higher than the number of people waiting for Adult Day services.

Of the thirteen Homemaker providers, five reported waiting lists in July 2008. The number of people on the waiting lists ranged from 1 to 126. Homemaker service funds remained unused at the end of the fiscal year. 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.

Of the fourteen Adult Day providers, two reported waiting lists in July 2008. The number of people on the waiting lists ranged from 4 to 7.

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



Data source: DAIL/DDAS SAMS database.

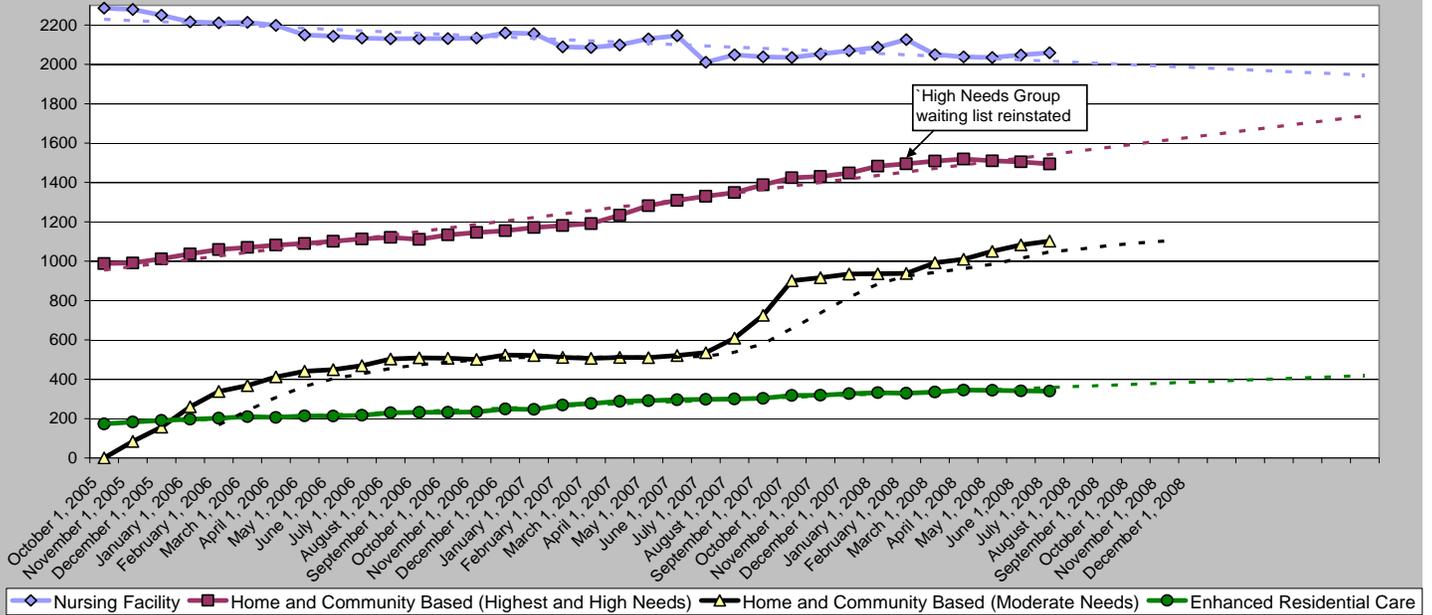
This graph shows trends in enrollment of people in the Highest Needs Group and the High Needs Group. All of these people met the ‘traditional’ nursing home clinical and functional eligibility criteria that existed before Choices for Care.

The number of people enrolled in these two eligibility groups has grown significantly. In two and a half years, the total has increased by more than 450 people (about 13%). This includes a decrease of about 250 people in nursing homes (about 11%), and an increase of about 700 people in home and community-based settings (about 60%).

Prior to Choices for Care, the number of people enrolled in HCBS and ERC settings increased by about 100 per year. During Choices for Care, the number of people enrolled in HCBS and ERC settings has increased by about 280 per year, while the number of people enrolled in the NF setting has decreased by about 100 per year.

It is not yet clear if these enrollment trends support or refute initial concerns about a ‘woodwork effect’, in which more people would enroll in Medicaid HCBS long term care services without reducing nursing home use and expenditures. This could cause increases in expenditures that are not sustainable in the long term.

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



Data source: DAIL/DDAS SAMS database.

**Nursing homes:** the number of people enrolled in the nursing home setting decreased by about 250 between October 2005 and April 2008. This was associated with a decrease in Vermont nursing home capacity, totaling 131 beds:

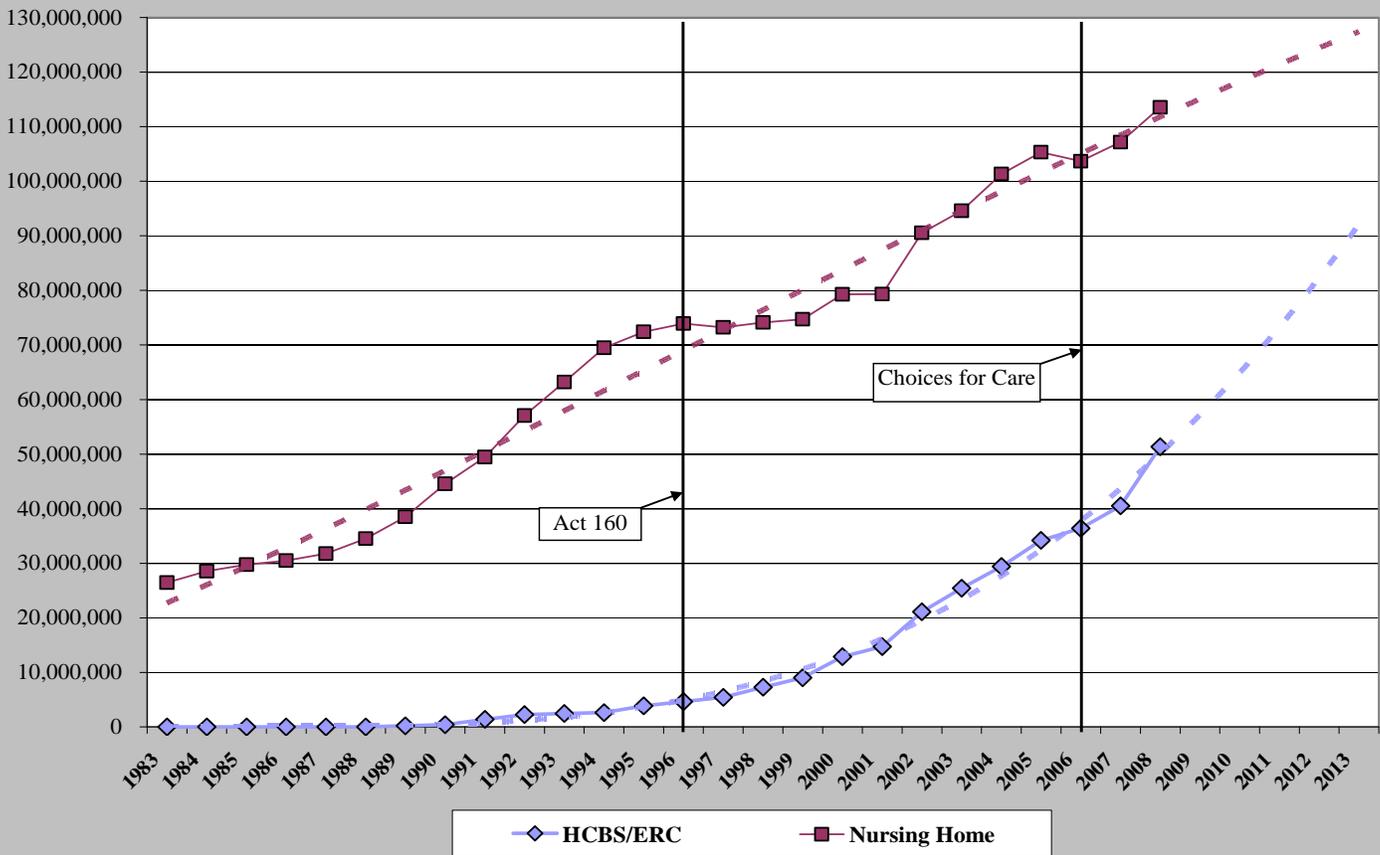
|            |                           |     |            |
|------------|---------------------------|-----|------------|
| Oct 2005   | Newport                   | -10 | Orleans    |
| Jan 2006   | Mt Ascutney               | -8  | Windsor    |
| Sept 2006  | Gifford                   | +10 | Orange     |
| 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 July 2008, the number of people enrolled increased by 506. The number of people has decreased slightly in the past few months

**Enhanced Residential Care:** between October 2005 and July 2008, the number of enrolled individuals increased by 167 (nearly 100%). Some people transitioned to ERC settings from Traumatic Brain Injury Waiver services and nursing homes, contributing to this increase.

**HCBS Moderate Needs Group:** this 'expansion' group was created in October 2005, and by July 2008 had grown to include more than 1100 people. Large increases in Moderate Needs Group enrollment in SFY2008 (nearly 600 people) were supported by an increase in MNG funding for Homemaker services.

### Vermont LTC Expenditures by Type, sfy1983-sfy2013



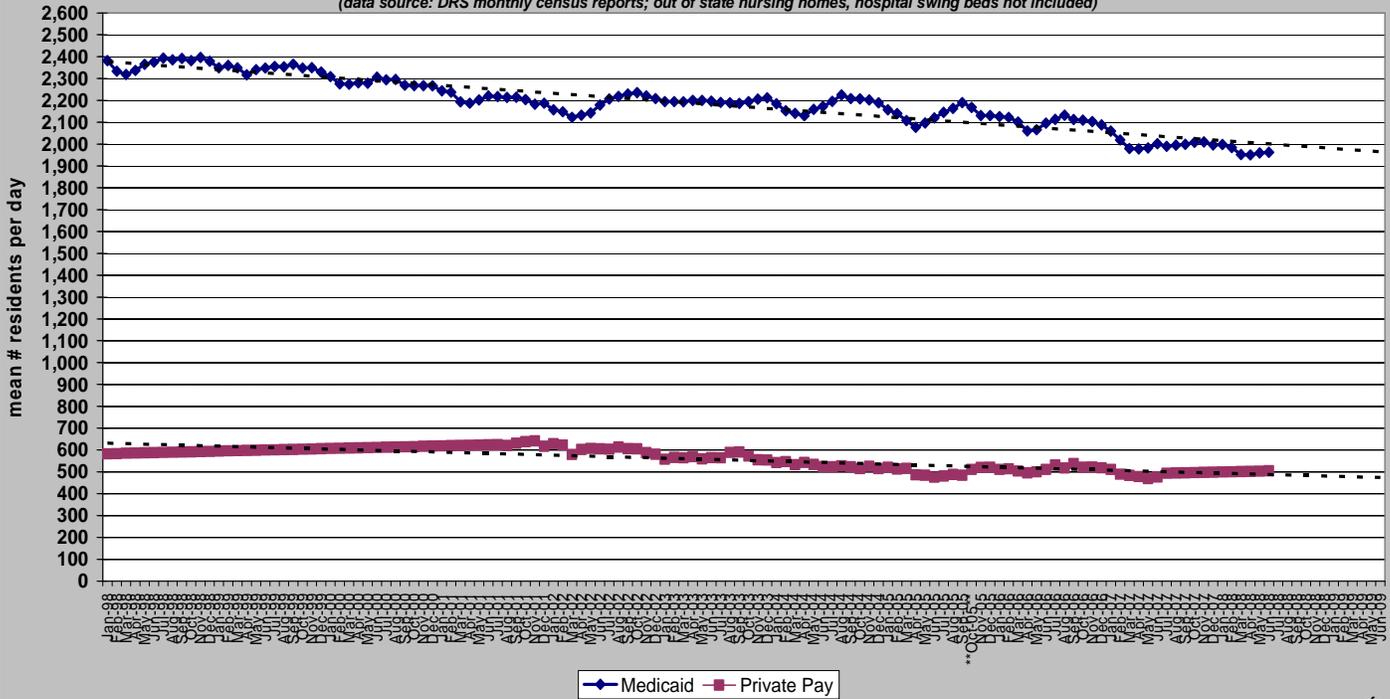
Data source: AHS financial reporting

Since SFY2000, Medicaid expenditures have increased by about \$32 million in the nursing home setting, and more than \$35 million in alternative settings. Between SFY2000 and SFY2005, nursing home expenditures grew by more than \$5 million per year; since Choices for Care was implemented in SFY2005, nursing home expenditures grew by less than \$2 million per year.

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 – including housing subsidies, transportation, food, and utilities. People in nursing homes and enhanced residential care tend to incur fewer of these other expenditures. This means that as HCBS expenditures increased, other expenditures for people served in the HCBS setting also increased.

### Vermont Nursing Home Bed Use: Medicaid and Private Pay Average Number of Residents per Day, sfy2001- sfy2009

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

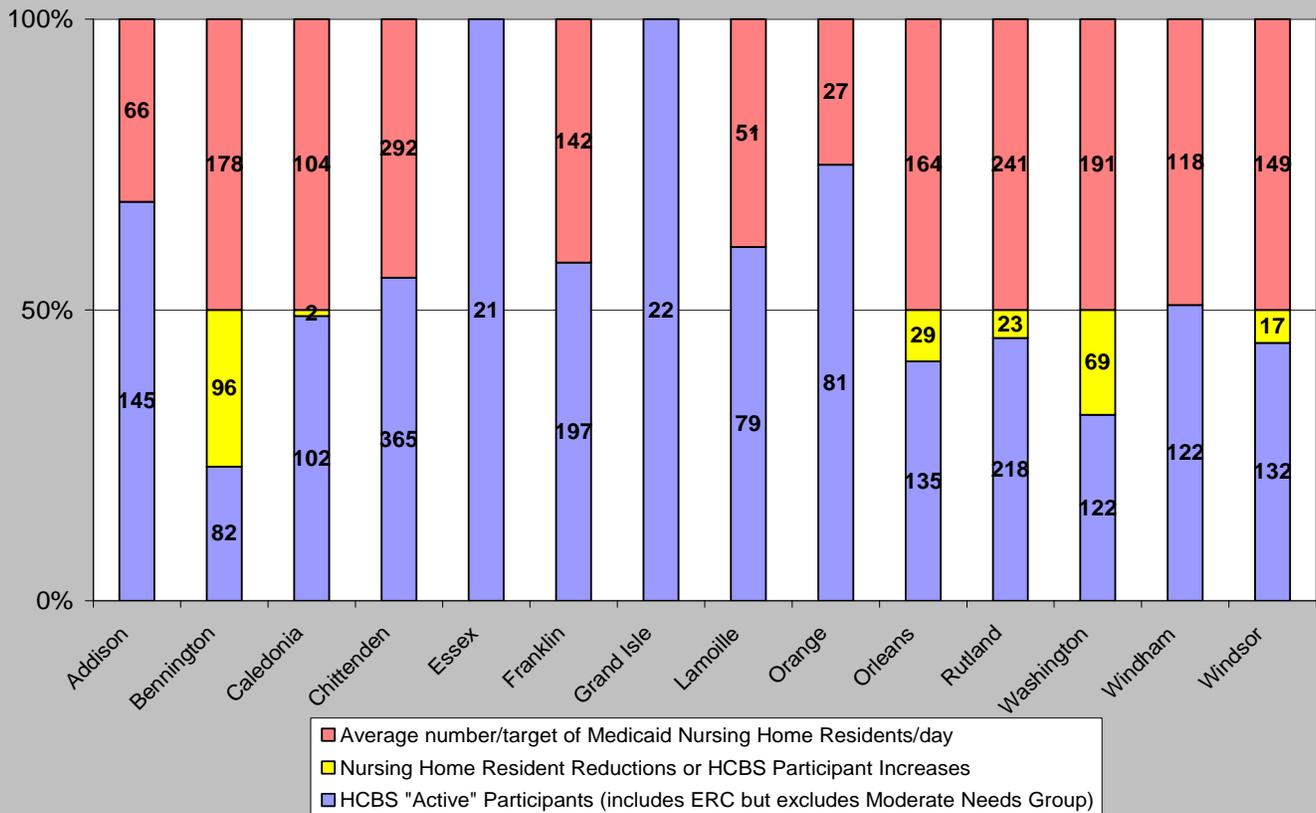


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Data source: DRS, monthly provider reports

The number of people in Vermont nursing homes with Medicaid as primary payor has decreased significantly since 2001- from about 2,400 to about 2,000. The number of people who pay privately has also decreased, from about 600 people to about 500 people.

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



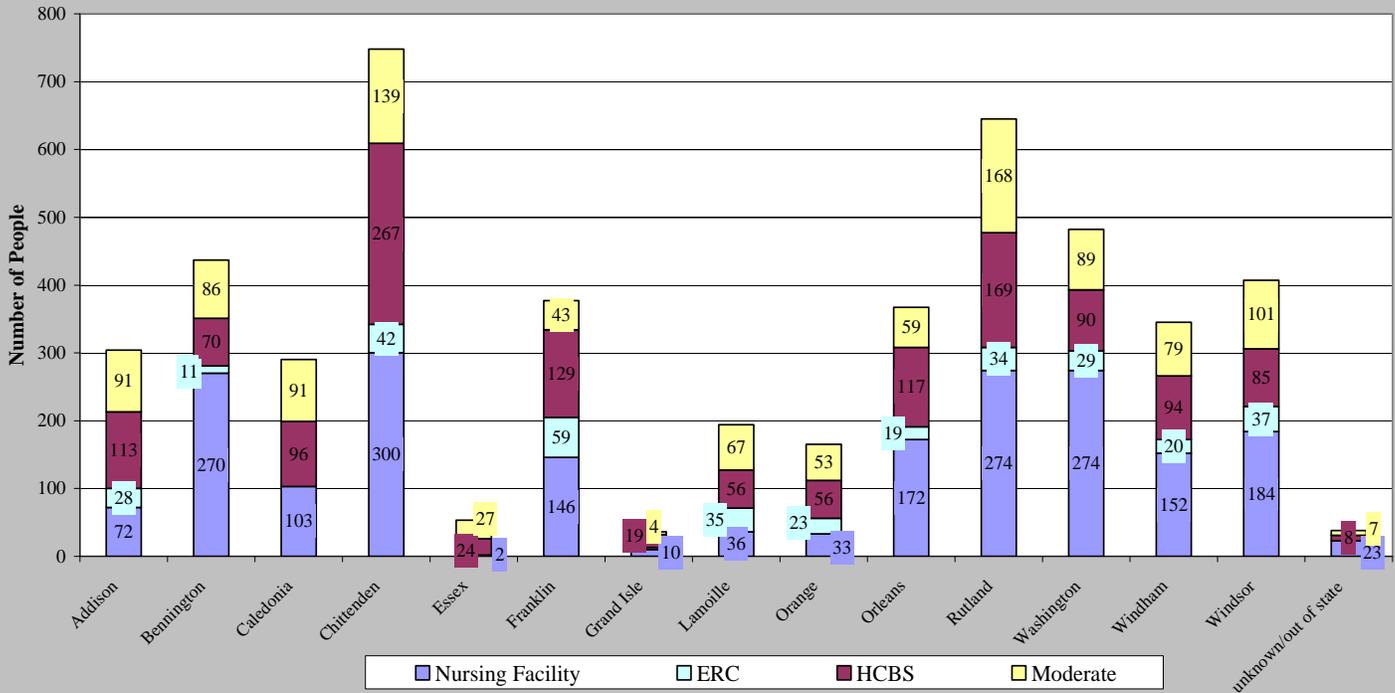
Data sources: DAIL/DDAS SAMS database; Division of Rate Setting.

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 April 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, Chittenden, Essex, Franklin, Grand Isle, Lamoille, Orange, and Windham), more than 50% of *Choices for Care* participants are served in alternative settings. People in the remaining counties (Bennington, Orleans, Rutland, Washington, Windsor, 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.

**Choices for Care: Enrolled Participants by Setting by County  
as of July 1, 2008**



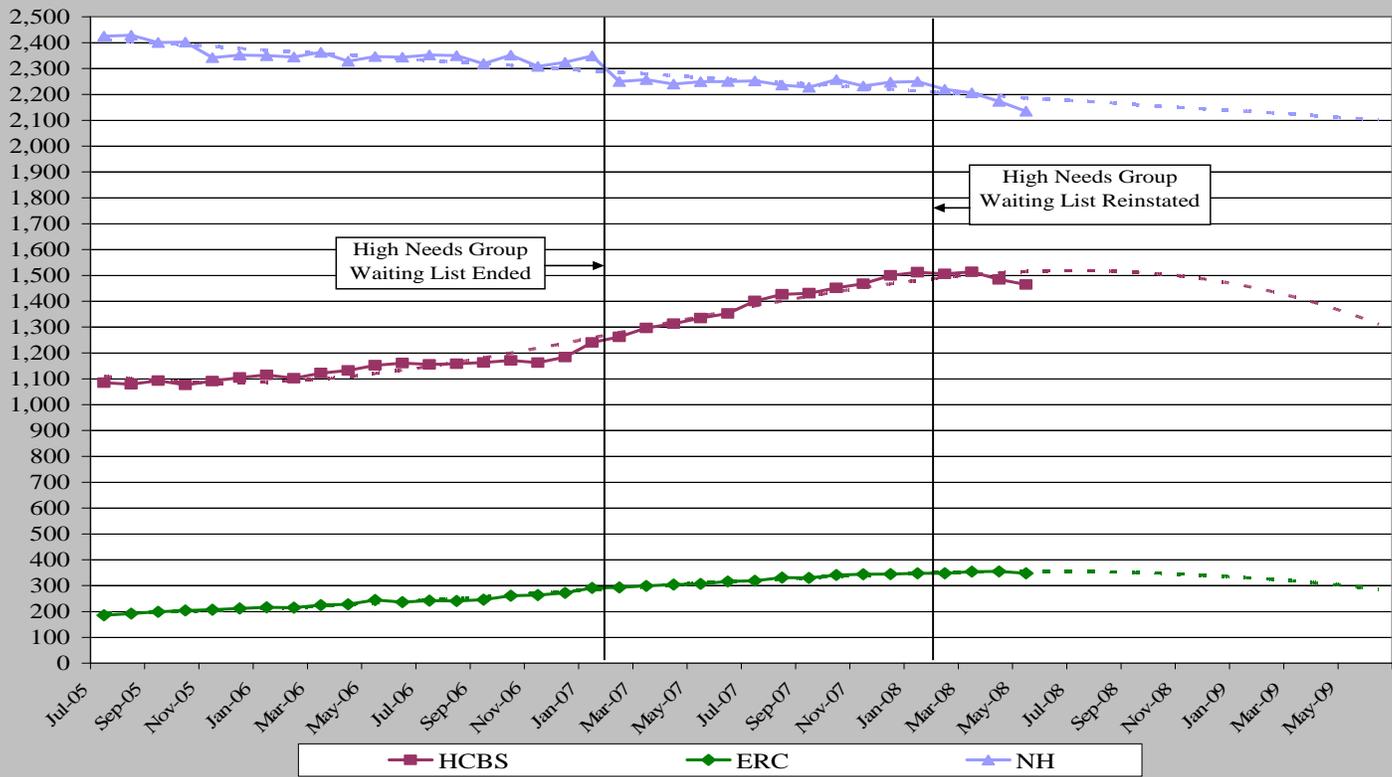
Data source: DAIL/DDAS SAMS database.

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, Orleans, Rutland, Washington and Windsor Counties, a relatively large proportion of people in the Highest and High Needs Groups are served in nursing facilities.

**Vermont: Choices for Care Participants by Setting, sfy2005 - sfy2008**

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



Data source: DAIL/DDAS SAMS database.

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.

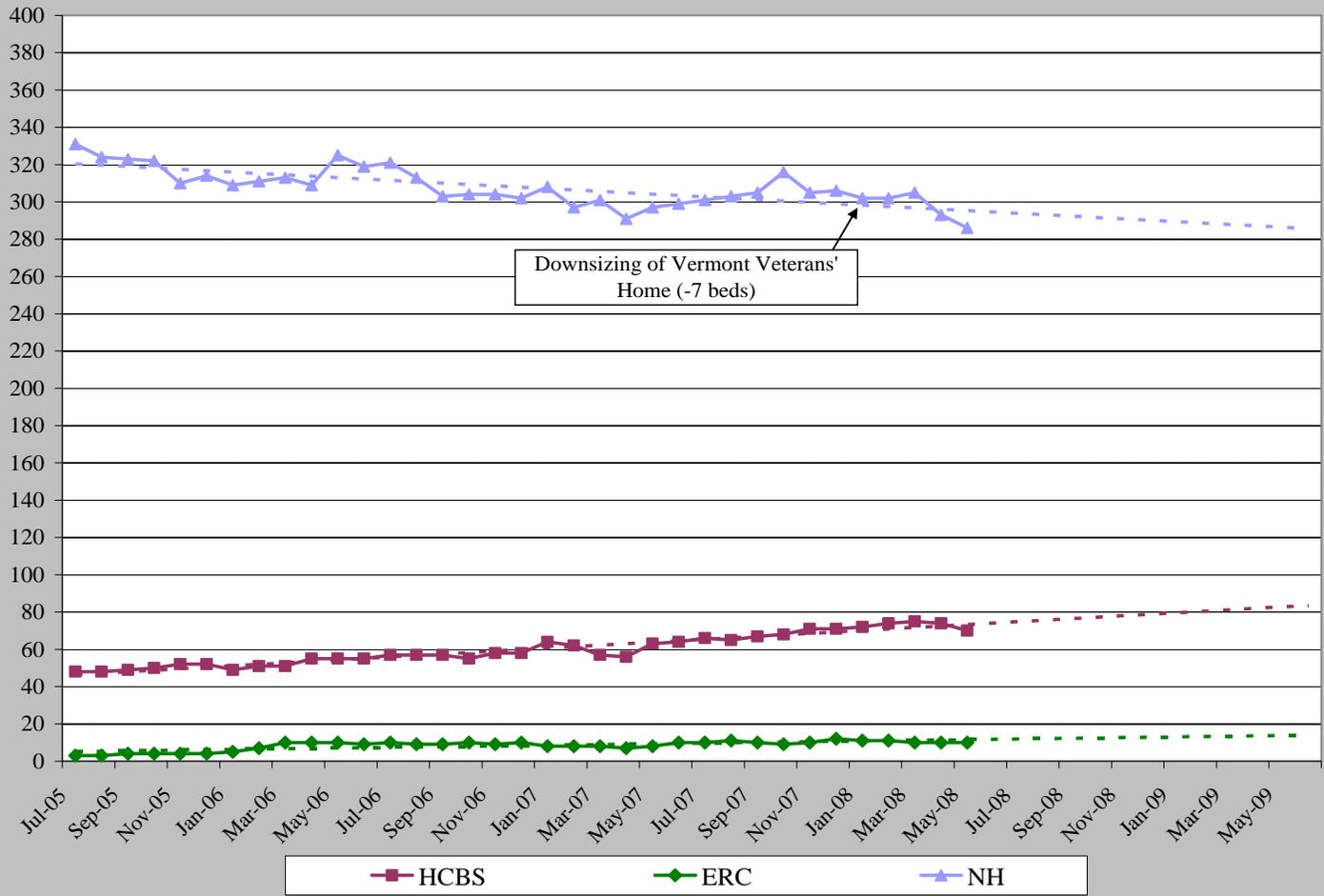
Large counties: Bennington, Chittenden, Rutland, Washington, Windsor

Medium counties: Franklin, Orleans, Windham

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

### Bennington County: Choices for Care Participants by Setting, sfy2005 - sfy2008

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

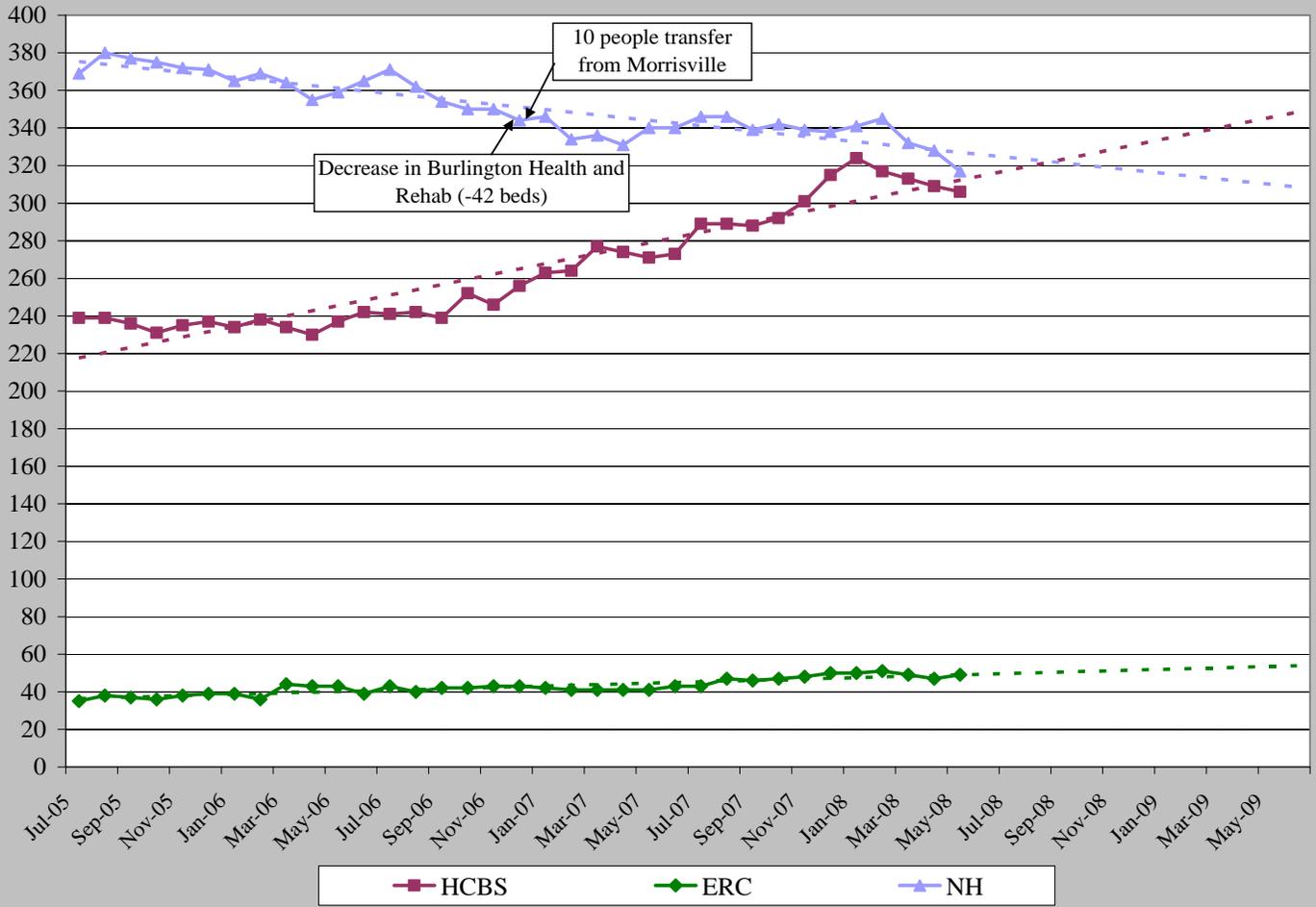


Data source: EDS paid claims

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 - sfy2008

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

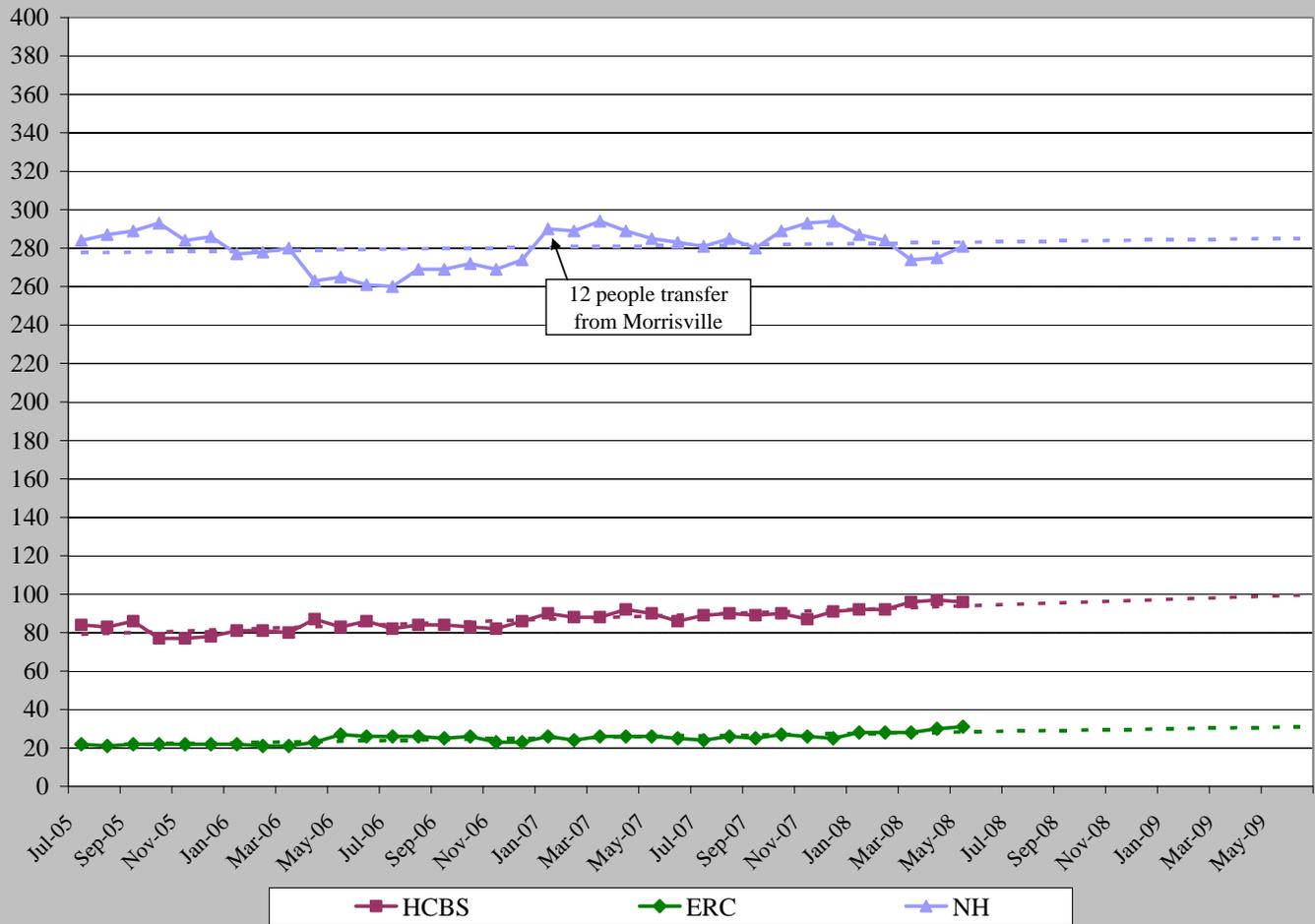


*Data source: EDS paid claims*

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

### Washington County: Choices for Care Participants by Setting, sfy2005 - sfy2008

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

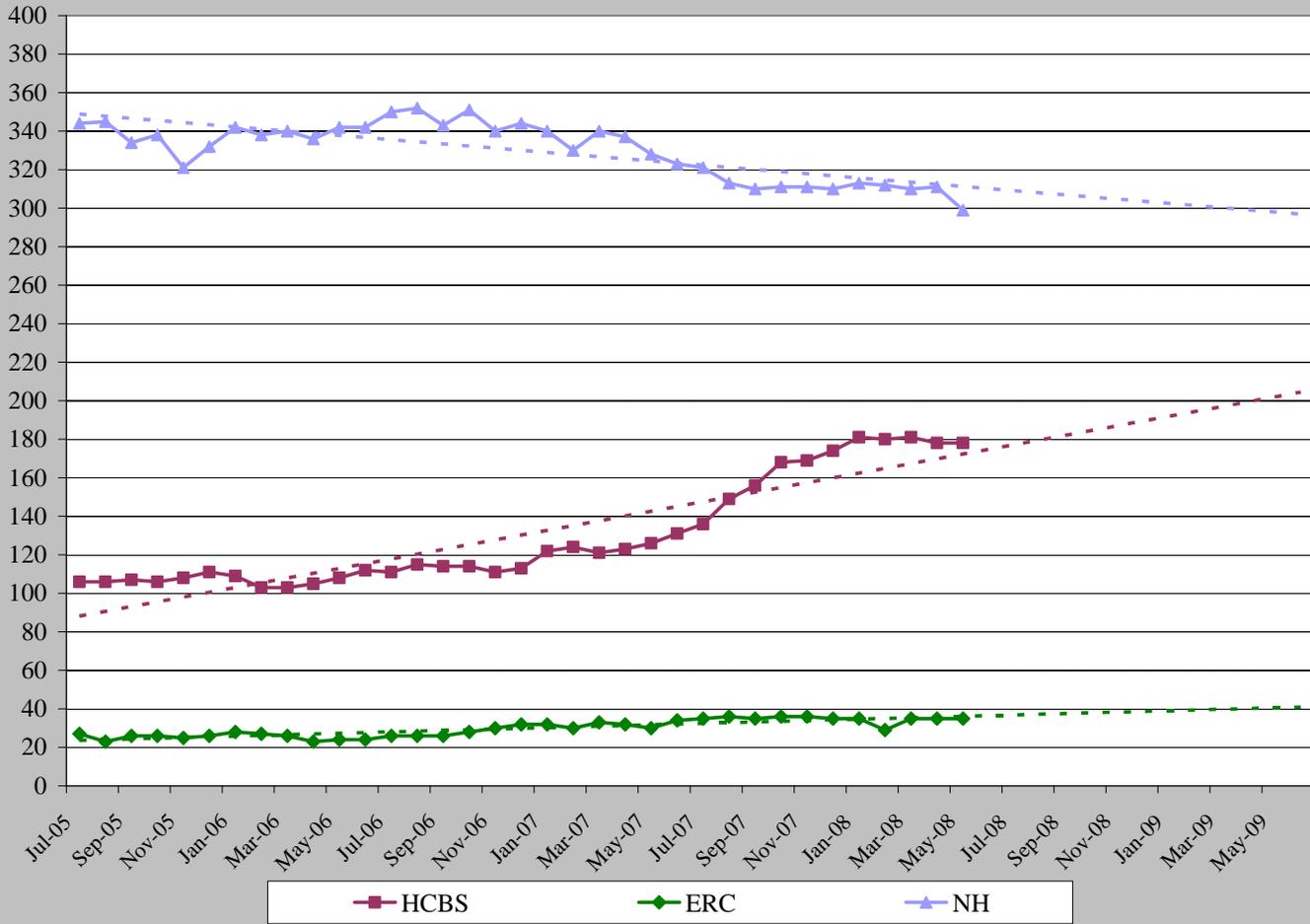


*Data source: EDS paid claims*

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. Twelve residents transferred from Lamoille County to Washington County upon the closing of the Morrisville nursing facility. While residents of Lamoille County may contribute to the use of nursing homes in Washington County, it appears that the expected outcome of Choices for Care has not been realized in Washington County.

### Rutland County: Choices for Care Participants by Setting, sfy2005 - sfy2008

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

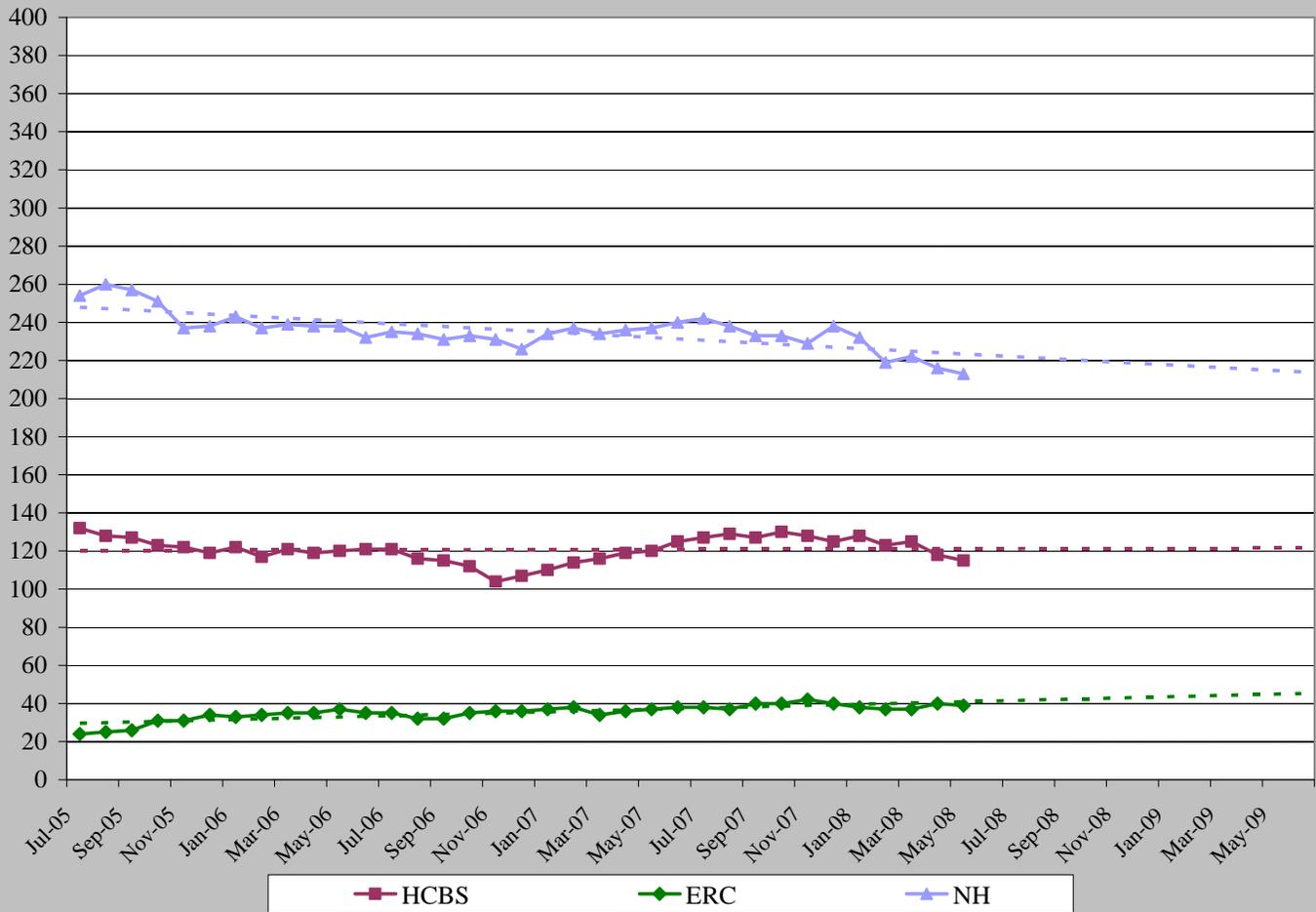


*Data source: EDS paid claims*

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.

### Windsor County: Choices for Care Participants by Setting, sfy2005 - sfy2008

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

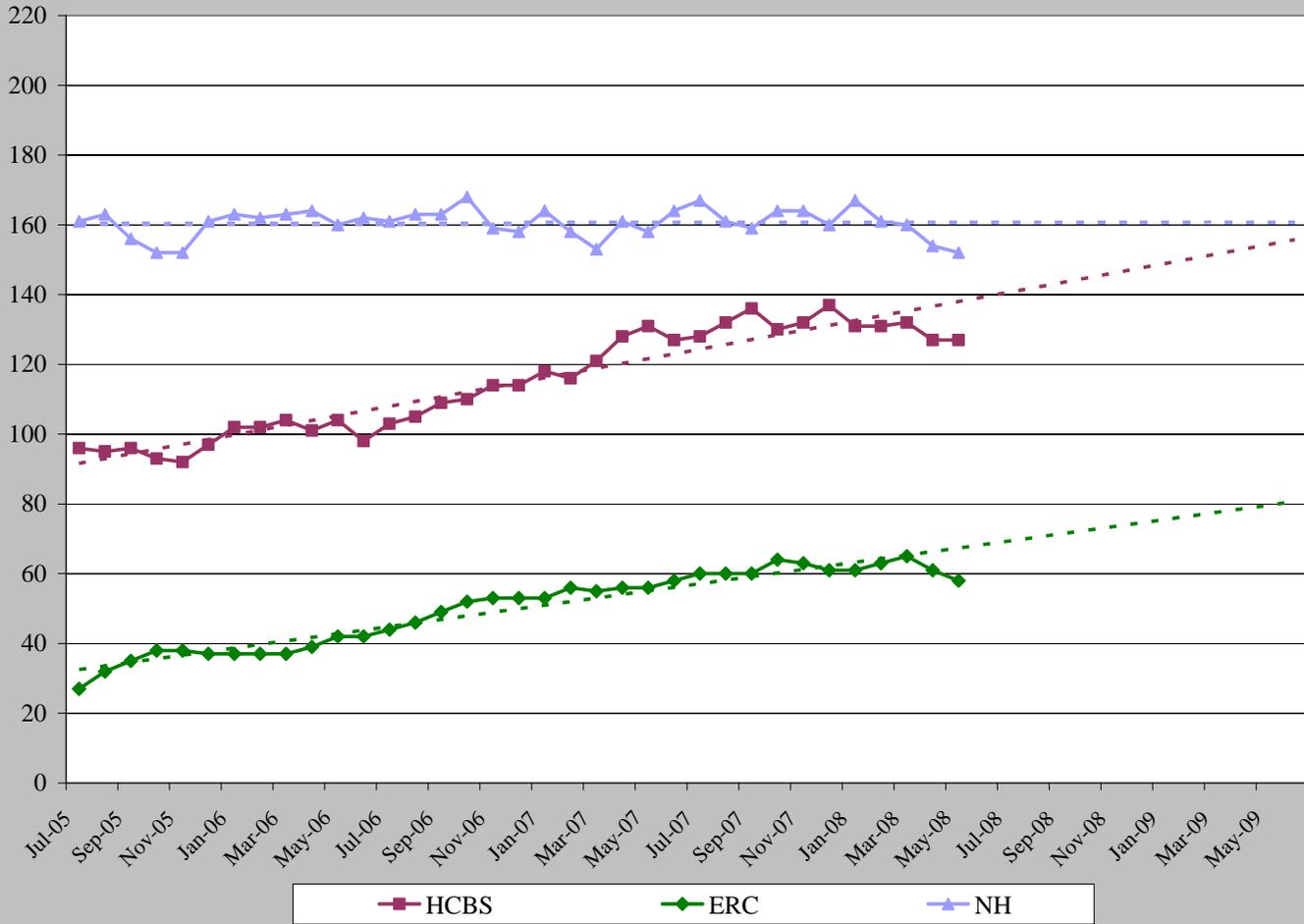


*Data source: EDS paid claims*

In Windsor County, use of ERC has increased since July 2005. The use of HCBS has decreased since July 2005. The use of nursing homes has slowly declined. 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 - sfy2008

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

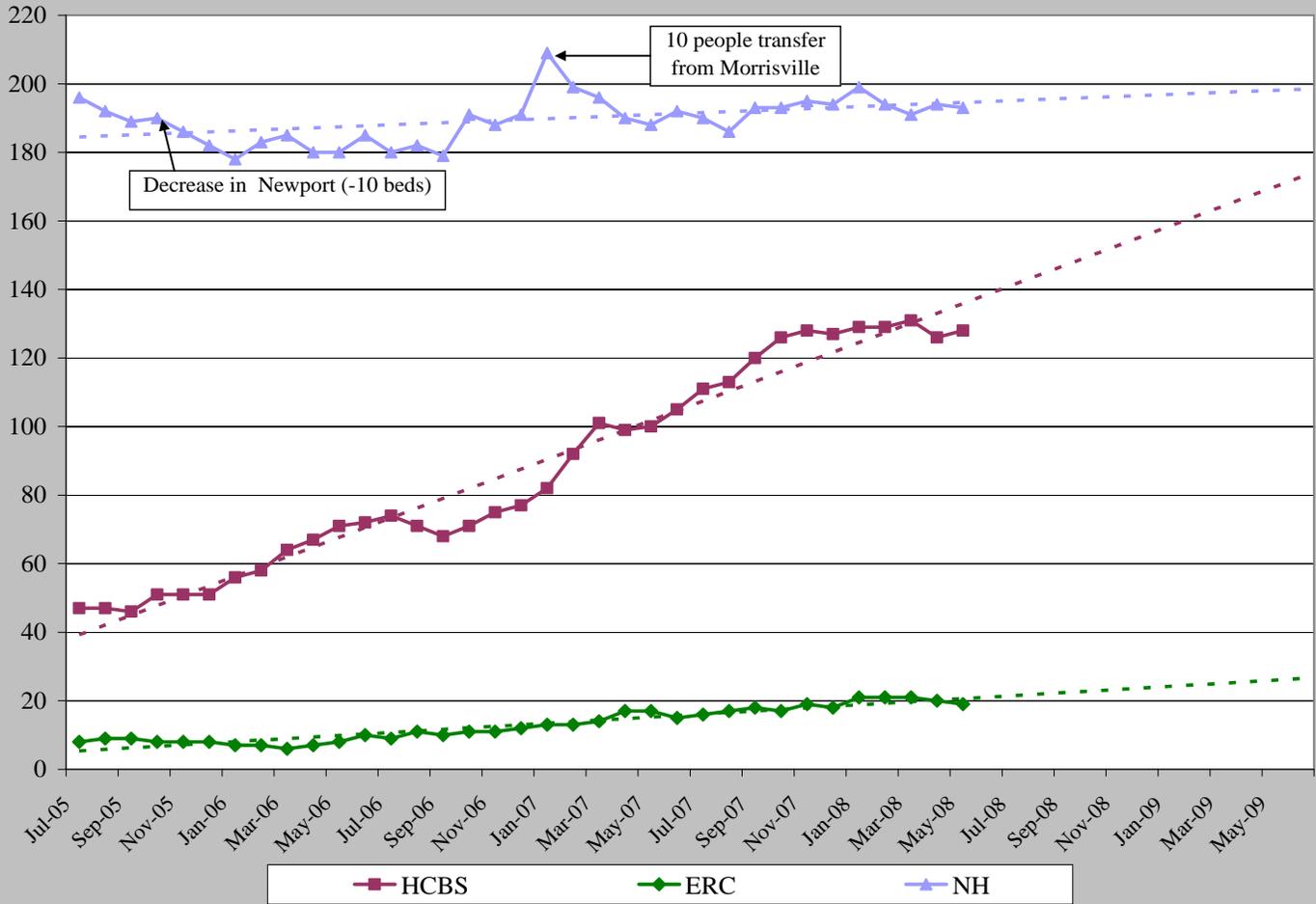


*Data source: EDS paid claims*

In Franklin County, use of both HCBS and ERC has increased steadily since July 2005. However, the use of nursing homes has remained fairly stable over time; it is not yet clear if the recent decreases in the use of nursing homes represent a new trend. 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 - sfy2008

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

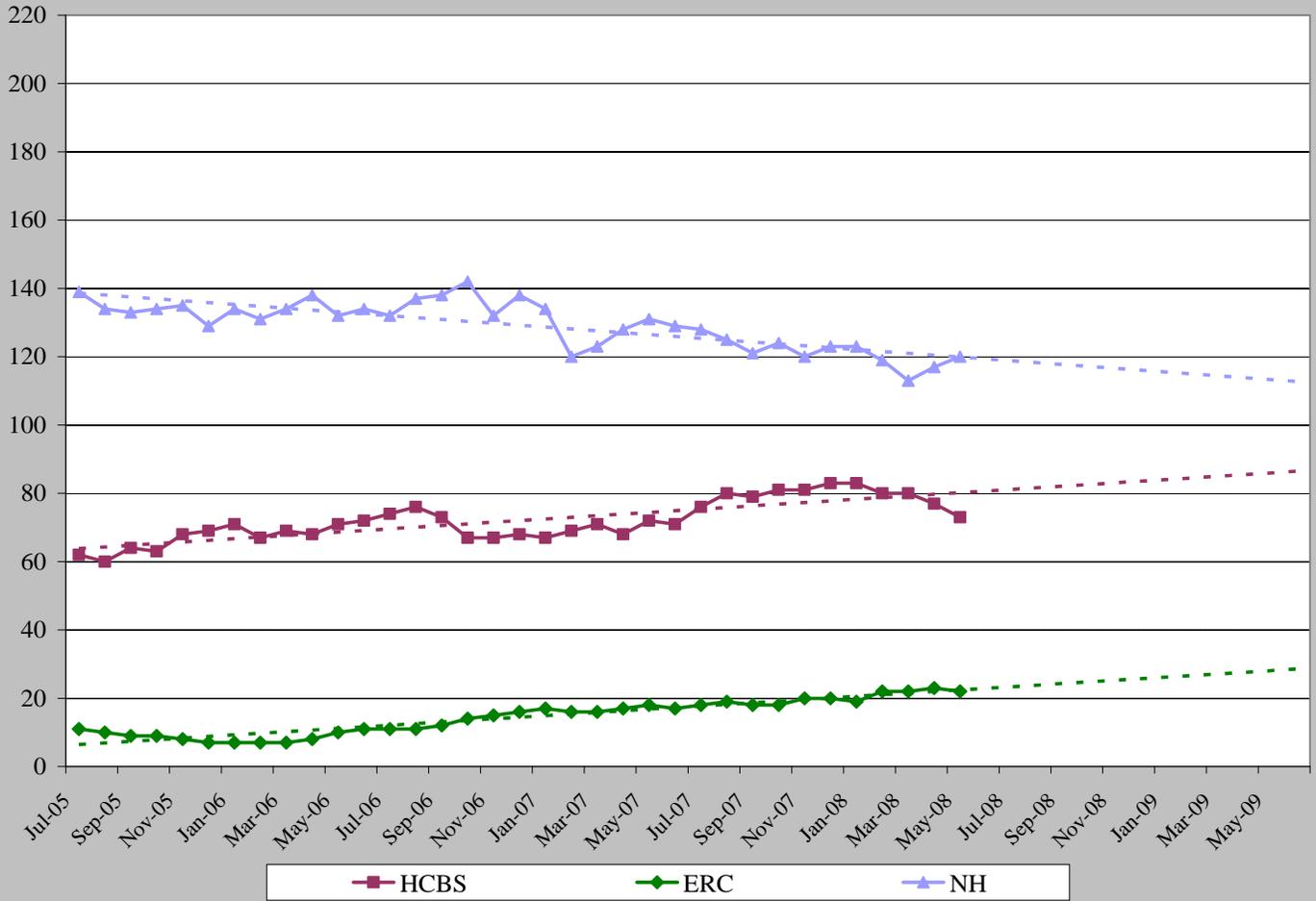


*Data source: EDS paid claims*

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 - sfy2008

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

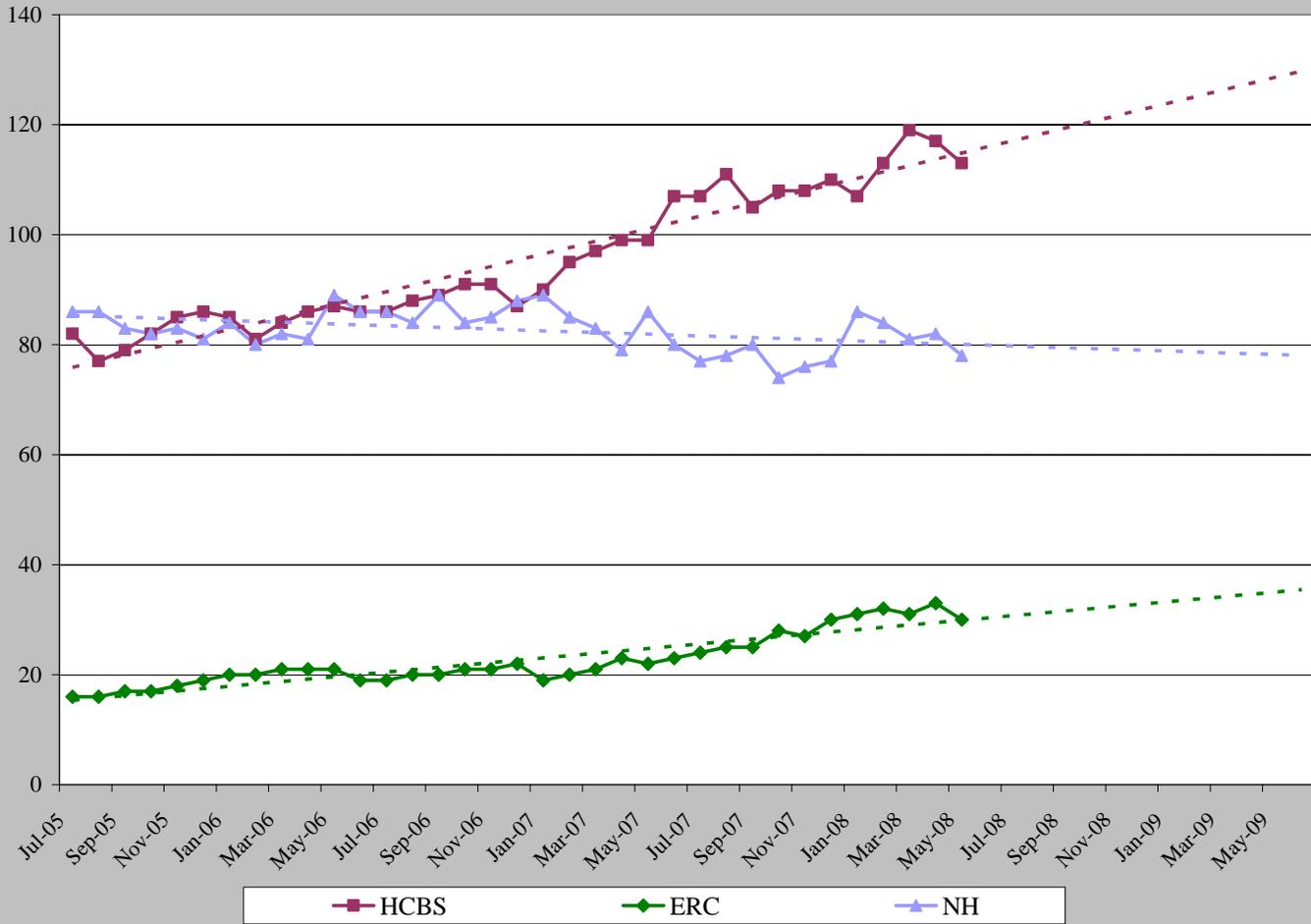


*Data source: EDS paid claims*

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

### Addison County: Choices for Care Participants by Setting, sfy2005 - sfy2008

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

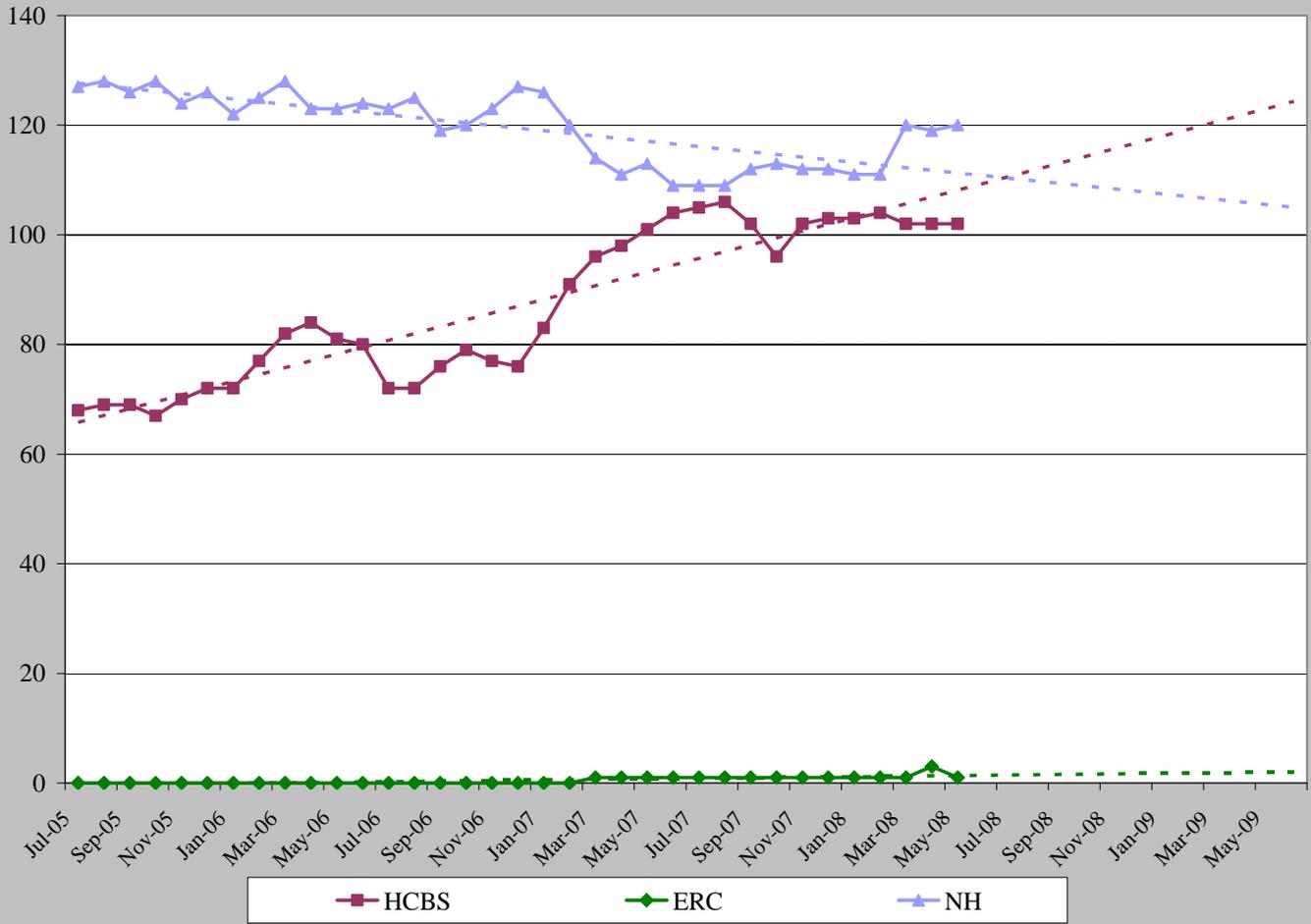


*Data source: EDS paid claims*

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. This is the expected outcome of Choices for Care.

### Caledonia County: Choices for Care Participants by Setting, sfy2005 - sfy2008

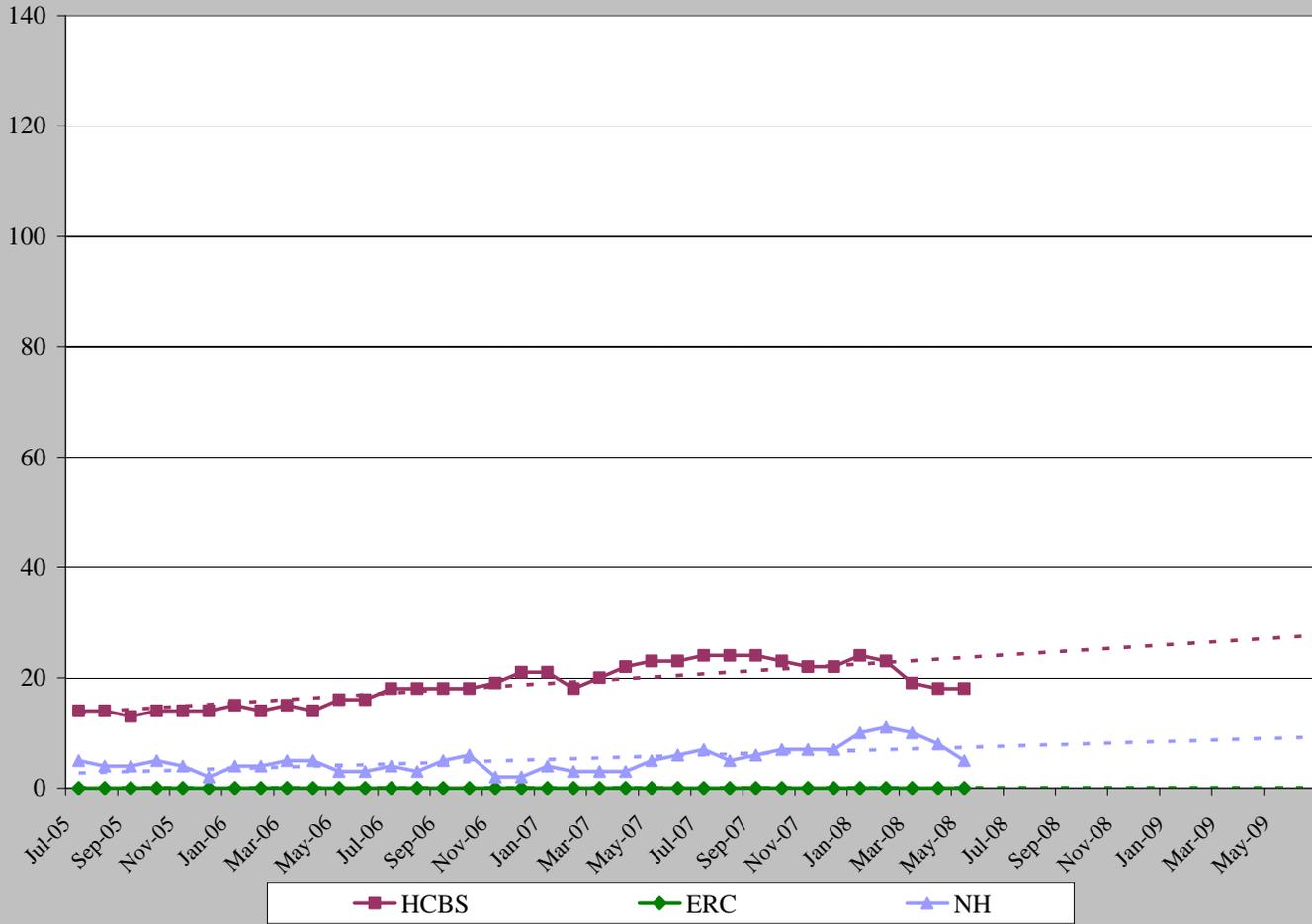
*data source: EDS paid claims by dates of service; excludes moderate needs group*



*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 - sfy2008**  
*data source: EDS paid claims by dates of service; excludes moderate needs group*

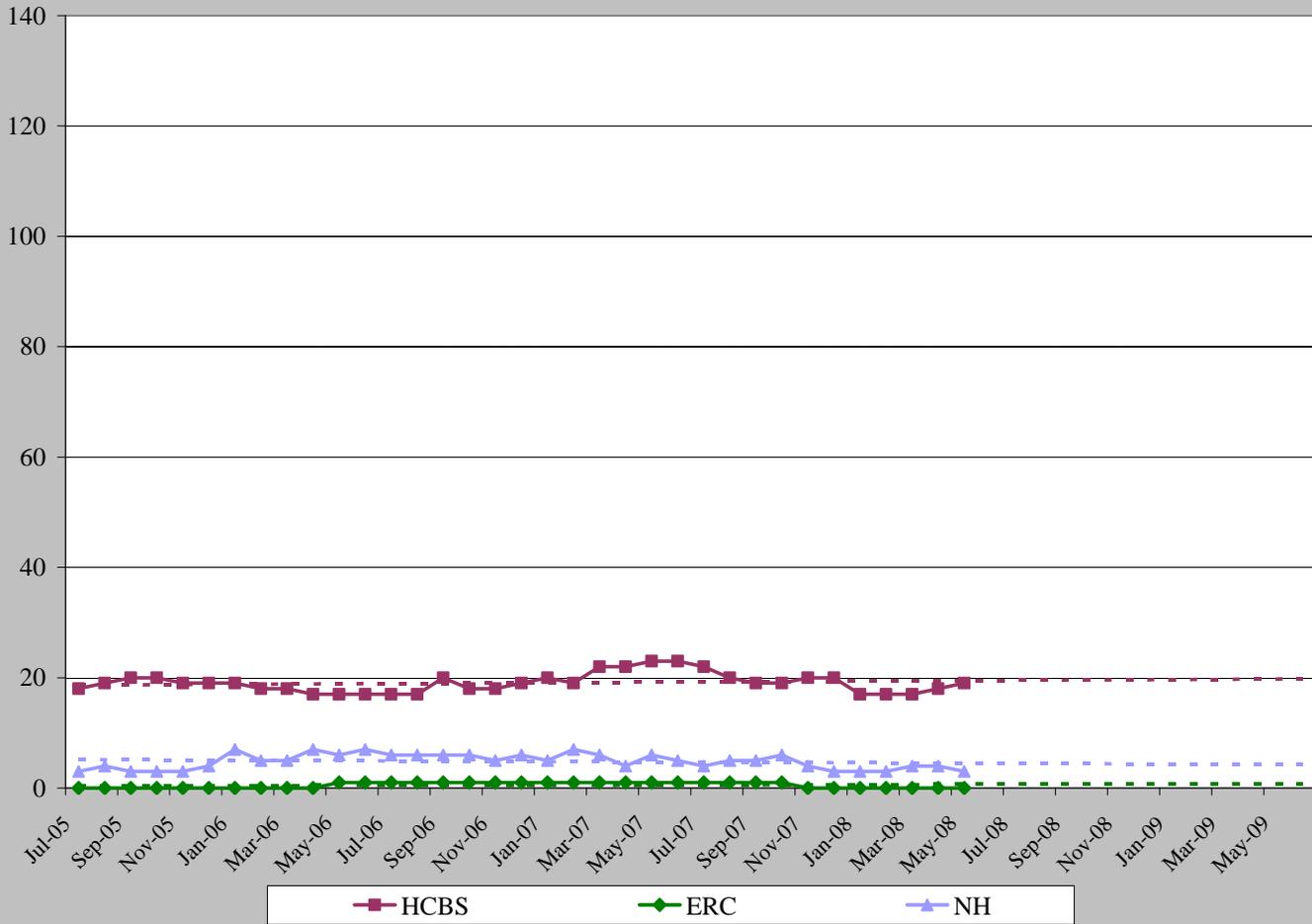


Data source: EDS paid claims

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 - sfy2008

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

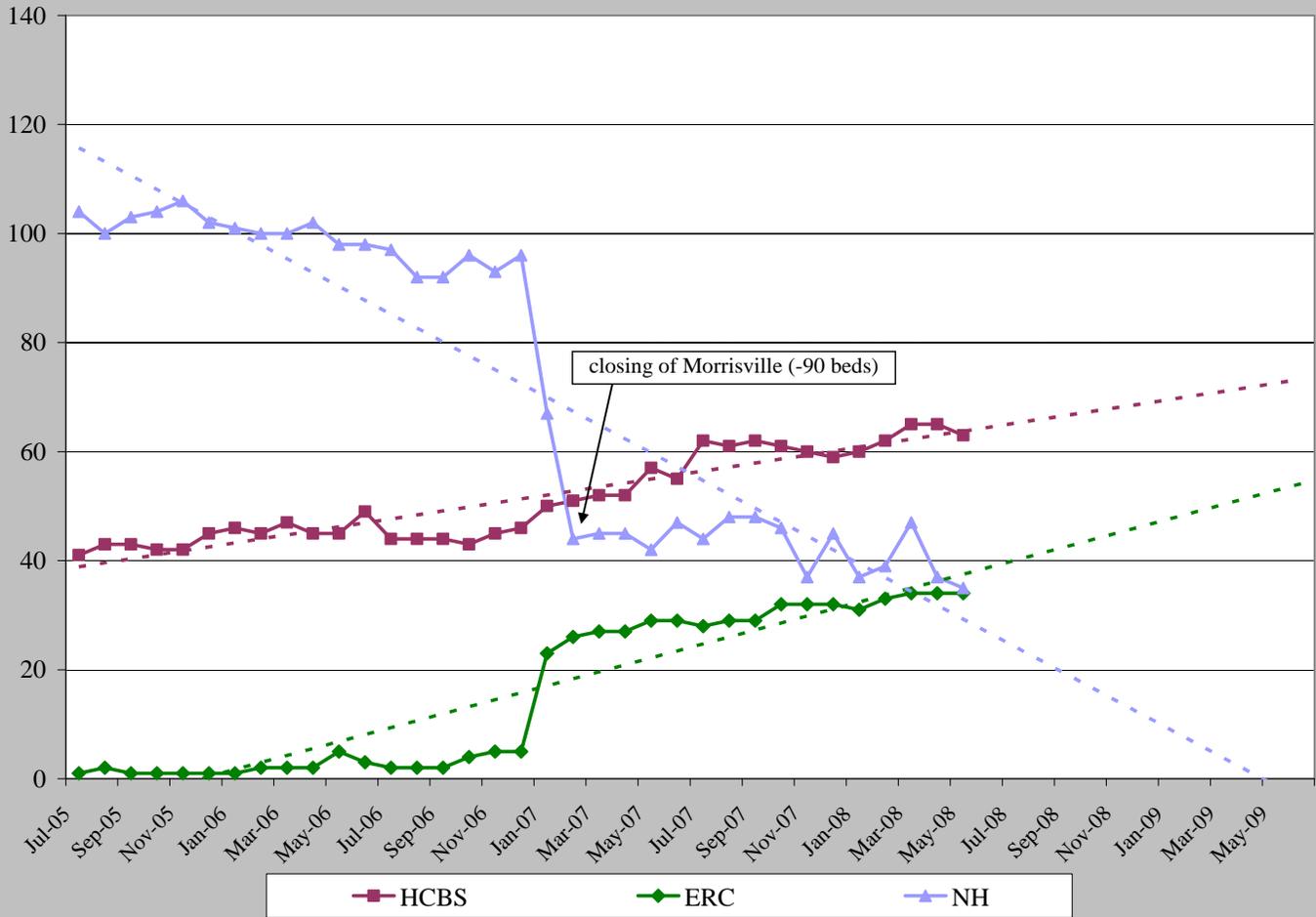


*Data source: EDS paid claims*

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 Essex County.

### Lamoille County: Choices for Care Participants by Setting, sfy2005 - sfy2008

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

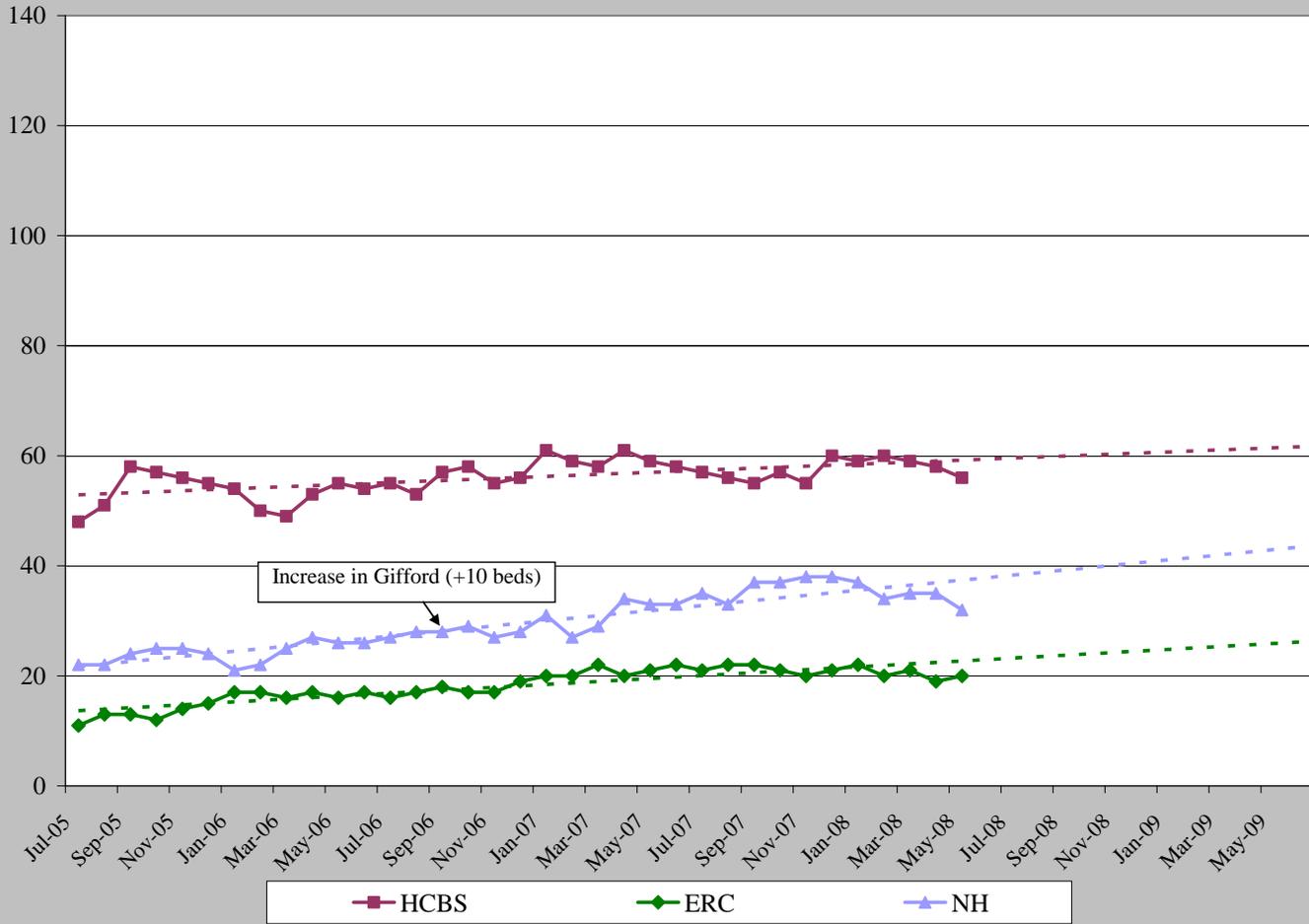


*Data source: EDS paid claims*

In Lamoille County, use of HCBS has increased since July 2005. The closing of the Morrisville Center facility in February 2007 caused a significant decrease in the use of nursing homes. This also caused a significant increase in the use of ERC, when some residents moved to Copley Manor Spruce House. While it is not clear if residents of Lamoille contribute to the use of nursing homes in other counties, it appears that the expected effect of Choices for Care has been realized in Lamoille County. Note that the July 2008 change in licensure of a number of beds at Copley- from ERC to nursing home- will impact this data in SFY2009.

### Orange County: Choices for Care Participants by Setting, sfy2005 - sfy2008

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



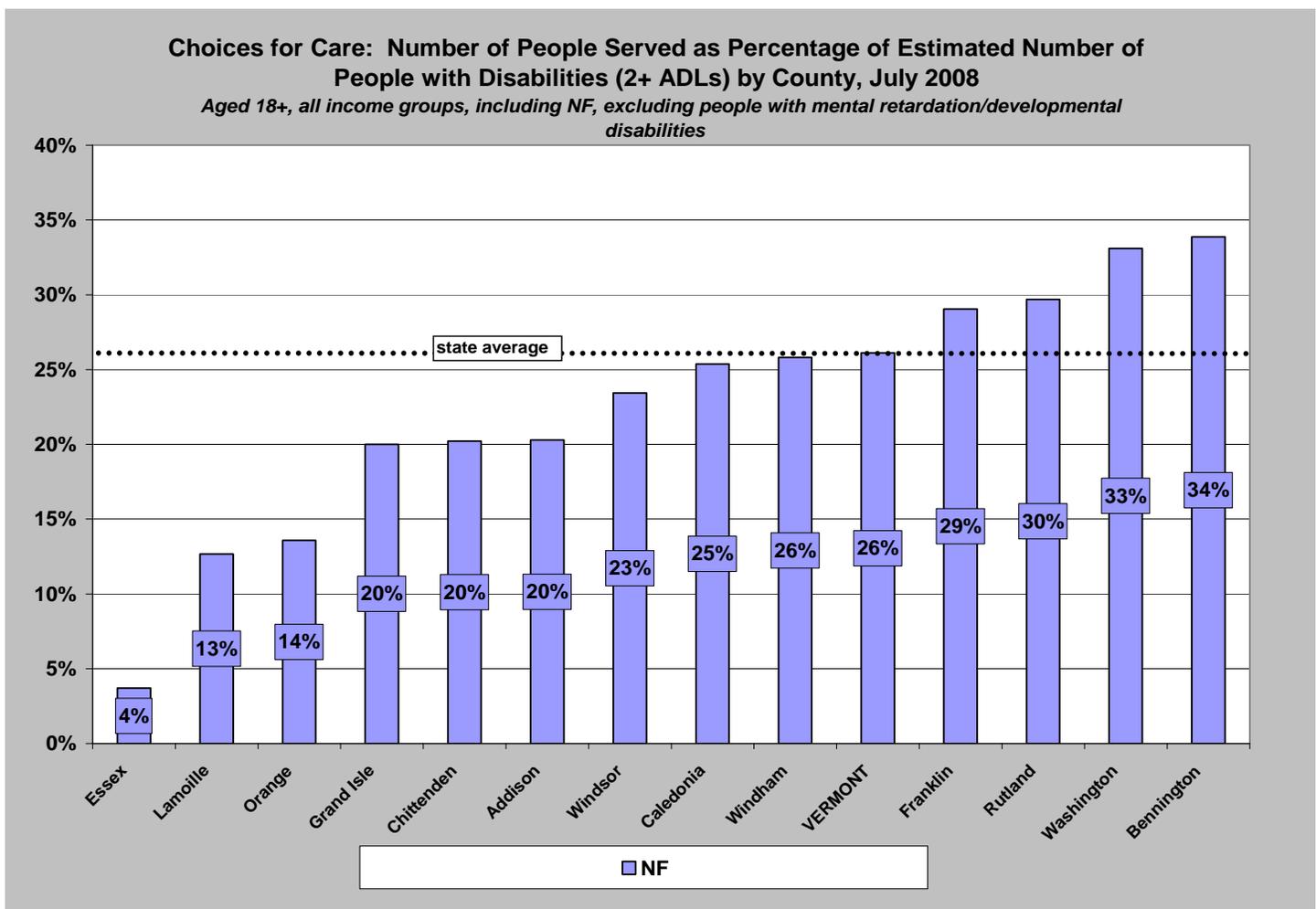
*Data source: EDS paid claims*

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.

The following graphs provide demographic perspectives on Choices for Care enrollment in each county, based on estimates of total demographic need. The Moderate Needs Group is not included.

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

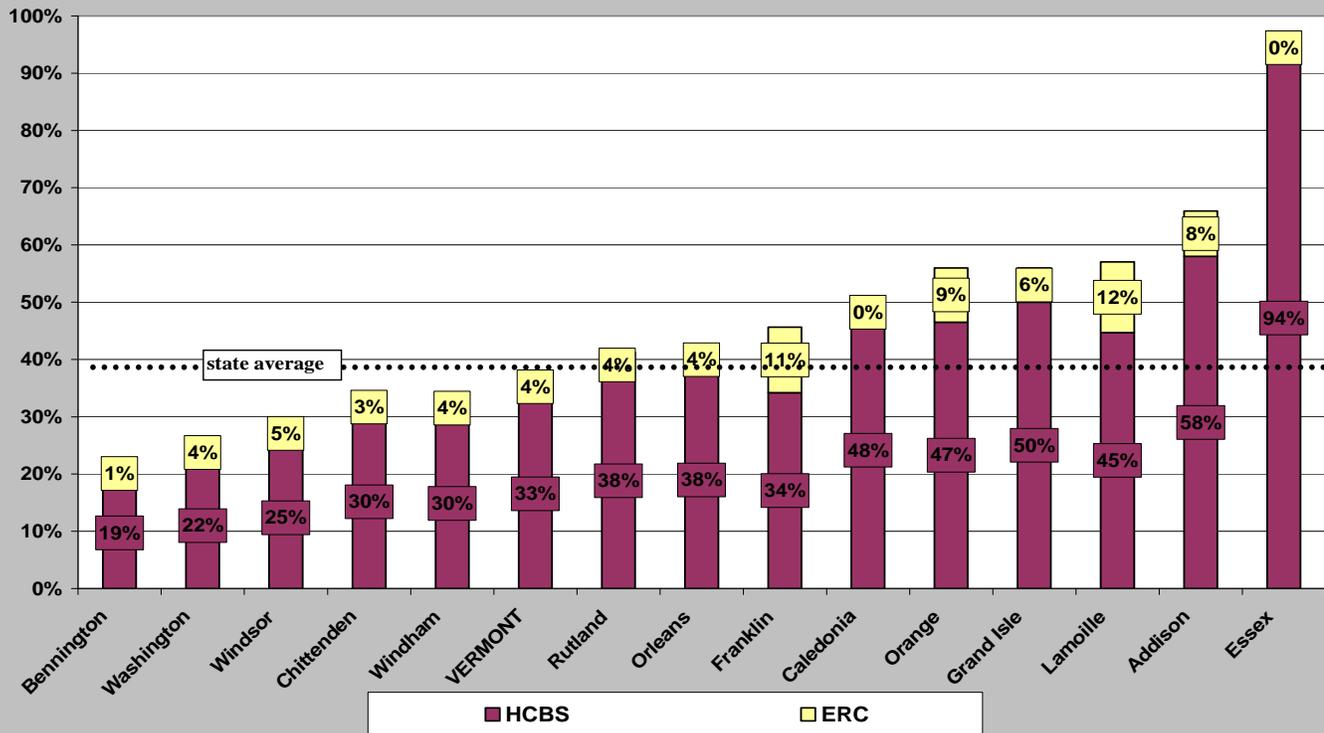
Note that this estimate of need is for all income groups, including people who are not financially eligible for Choices for Care. The estimate also includes people whose needs are met by other funding sources and programs (Medicare, community Medicaid, private insurance, Traumatic Brain Injury Waiver, 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, the graphs do describe the relative percentages of people who are served within each county.



Data sources: DAIL/DDAS SAMS database; Shaping the Future of Long Term Care and Independent Living 2006-2016.

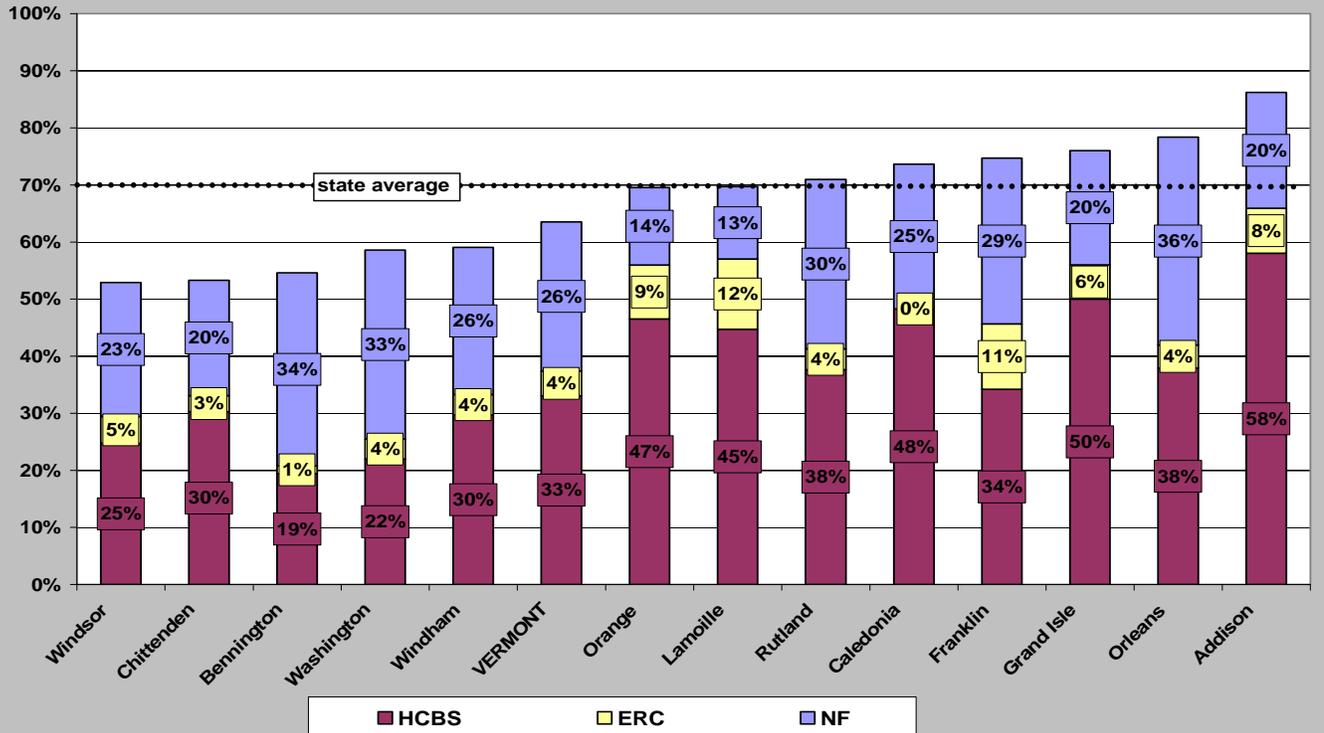
### Choices for Care: Number of People Served by Setting as a Percentage of Estimated Community Need by County - July 2008

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



### Choices for Care: People Served in LTC by Setting as a Percentage of Total Need by County - July 2008

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



Data sources: DAIL/DDAS SAMS database; *Shaping the Future of Long Term Care and Independent Living 2006-2016*

Nursing home capacity is a factor in actual nursing home use, and the use of home and community based services can be related to nursing home capacity. Increased use of home and community-based services may contribute to bed reductions; conversely, bed reductions may contribute to increased use of home and community-based services. During Choices for Care, the number of available nursing home beds was reduced in Chittenden, Lamoille, Orleans and Windsor Counties. The increased use of home and community-based services appears to have contributed to some of these reductions.

| Date                  | Facility                  | Decreases   | Increases | County               | Status    |
|-----------------------|---------------------------|-------------|-----------|----------------------|-----------|
| Oct 1996              | Maple Lane                |             | 4         | Orleans              |           |
| Jan 1998              | Brookside-Bradford        |             | 4         | Orange               |           |
| April 1998            | Sager                     | -3          |           | Rutland              |           |
| June 1998             | Veterans Home             | -1          |           | Bennington           |           |
| Dec 1998              | Gifford                   | -53         |           | Orange               | Closed    |
| Dec 1998              | Copley                    | -10         |           | Lamoille             |           |
| May 2000              | Copley                    | -10         |           | Lamoille             |           |
| June 2000             | Clarks                    | -17         |           | Addison              | Closed    |
| Jan 2001              | Helen Porter              | -13         |           | Addison              |           |
| May 2001              | Gifford                   |             | 20        | Orange               | Re-opened |
| June 2001             | Linden Lodge              | -117        |           | Windham              | Closed    |
| Dec 2001              | Sager                     | -33         |           | Rutland              | Closed    |
| July 2002             | Copley                    |             | 10        | Lamoille             |           |
| Oct 2002              | Stratton House            | -18         |           | Windham              | Closed    |
| Oct 2002              | Mt Ascutney               | -8          |           | Windsor              |           |
| Sept 2003             | Eden Park-Brattleboro     | -44         |           | Windham              |           |
| Feb 2004              | Brookside-Bradford        | -80         |           | Orange               | Closed    |
| <b>Total, pre-CFC</b> |                           | <b>-407</b> | <b>38</b> | <b>Net - 41/year</b> |           |
| 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             | Closed    |
| 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             |           |
| <b>Total, pre-CFC</b> |                           | <b>-191</b> | <b>60</b> | <b>Net - 44/year</b> |           |
| TOTAL                 |                           | -598        | 98        |                      |           |
| <b>NET:</b>           |                           | <b>-500</b> |           |                      |           |

In an AARP survey conducted in Vermont in 2002, 93% of a random sample of AARP members said that it would be important to them to have long-term care services that would enable them, or a family member, to stay at home as long as possible (*AARP Vermont Member Survey: Long-Term Care, 2003*). This is consistent with the core concept in Choices for Care: since most people state a preference for home and community based settings, they will tend to choose home and community-based settings when they are given a choice.

If this is true, increased use of home and community-based services should be correlated with decreased use of nursing homes, as eligible Vermonters disproportionately choose one setting over the other. The table below shows the changes in the use of each setting in Vermont counties between October 2005 and May 2008. The highlighted numbers indicate those areas where changes in use differed from the rest of the state.

### Changes in Use of CFC Services by County October 2005 - May 2008

|            | <u>HCBS</u> | <u>ERC</u> | <u>NH</u> |
|------------|-------------|------------|-----------|
| ADDISON    | 31          | 13         | -4        |
| BENNINGTON | 20          | 6          | -36       |
| CALEDONIA  | 35          | 1          | -8        |
| CHITTENDEN | 75          | 13         | -58       |
| ESSEX      | 4           | na**       | na*       |
| FRANKLIN   | 34          | 20         | 0         |
| GRAND ISLE | -1          | na**       | na*       |
| LAMOILLE   | 21          | 33         | -69       |
| ORANGE     | -1          | 8          | 7         |
| ORLEANS    | 77          | 11         | 3         |
| RUTLAND    | 72          | 9          | -39       |
| WASHINGTON | 19          | 9          | -12       |
| WINDHAM    | 10          | 13         | -14       |
| WINDSOR    | -8          | 8          | -38       |
| Vermont    | 389         | 144        | -267      |

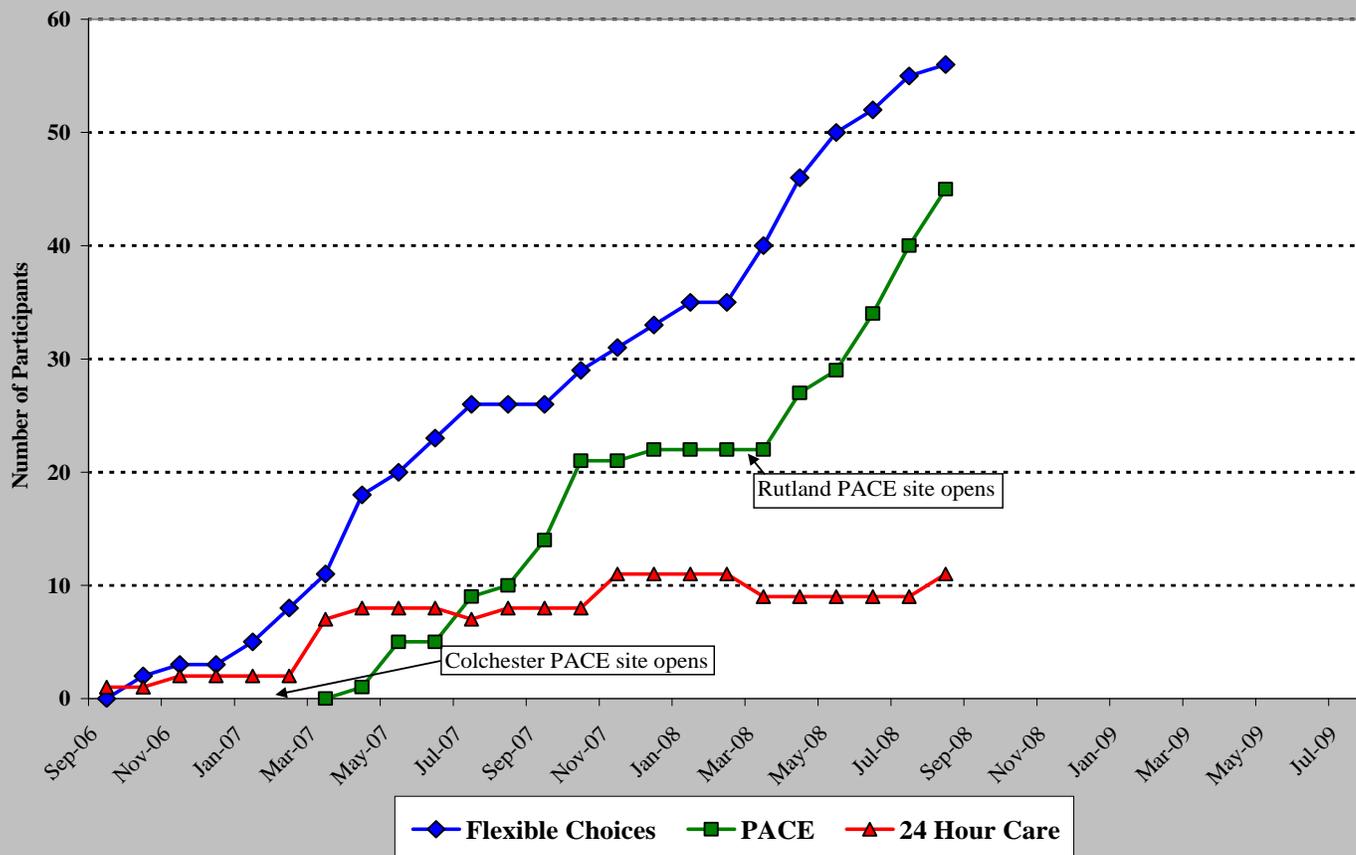
\* no nursing homes in county

\*\* no ERC facility in county

Data source: EDS paid claims, by date of service

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

*October-December 2007 data estimated*



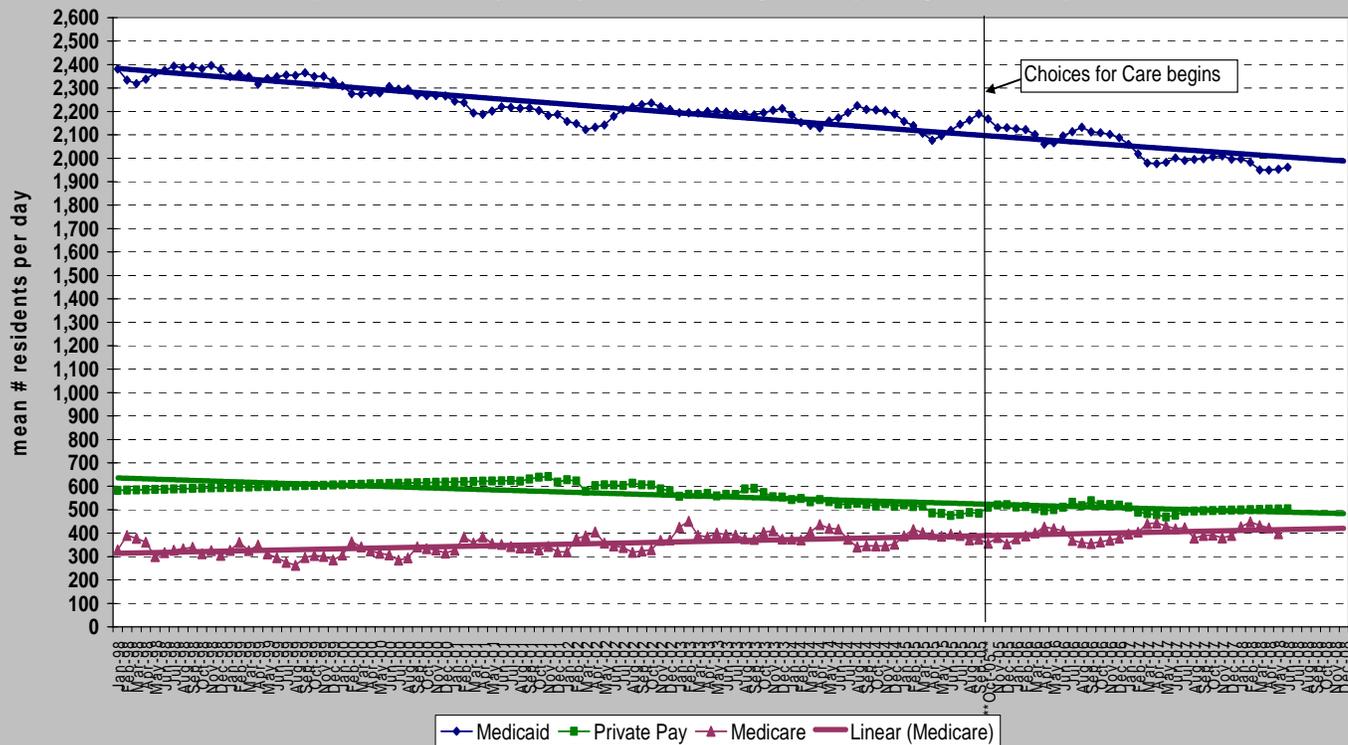
Data source: DAIL/DDAS SAMS database

One objective of Choices for Care is to expand the range of service options. This shows the history of enrollment in three new 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 represents a very 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.

## Vermont Nursing Home Bed Use: Medicaid, Medicare and Private Pay Average Number of Residents per Day, July 2001- July 2008

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



cfc 18

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

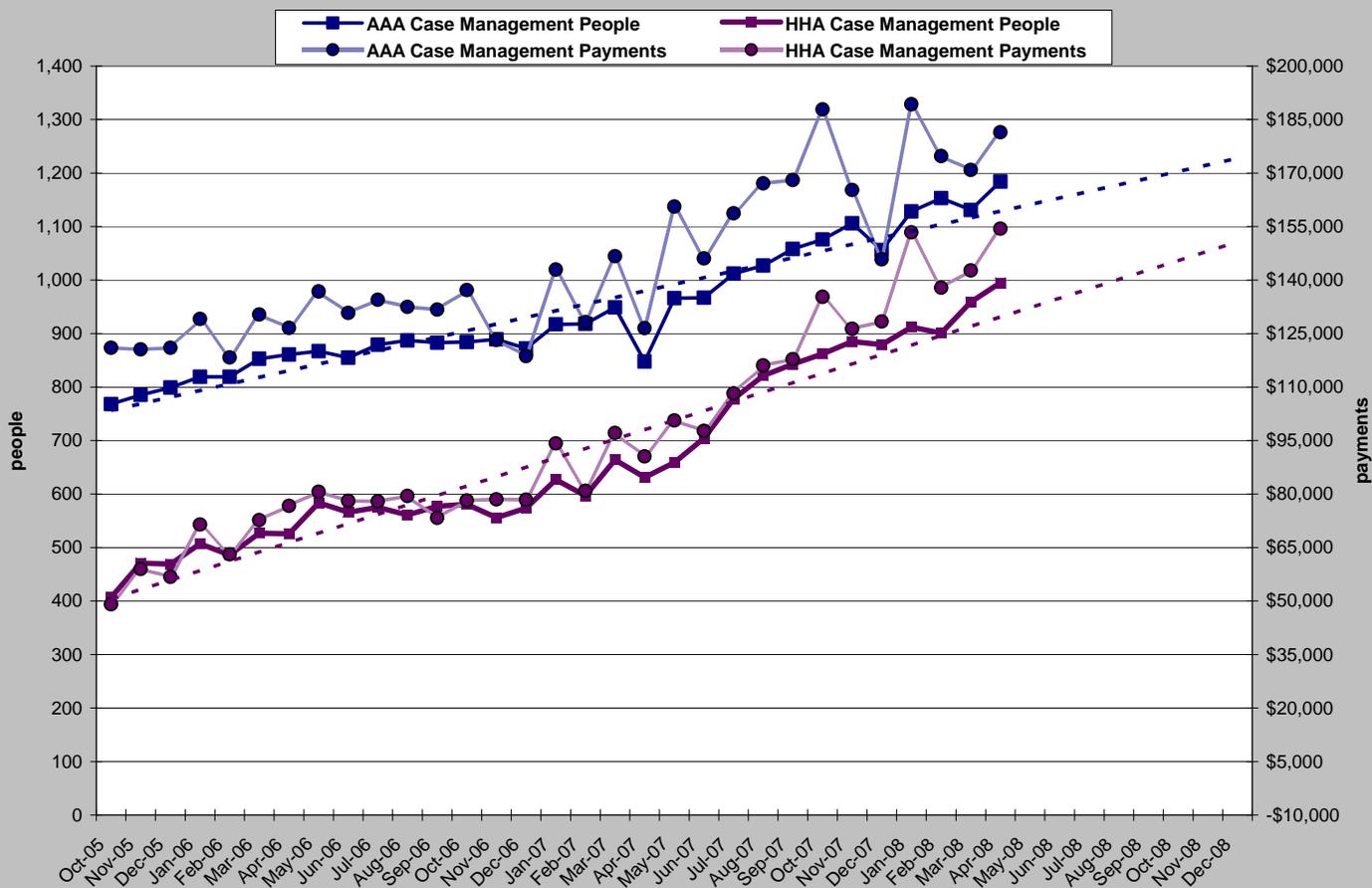
This shows trends in the use of Vermont nursing homes for residents whose primary payment source was Medicaid, private pay, or Medicare. The average occupancy figures are derived from monthly days of service reported to the Division of Rate Setting by Vermont nursing homes.

The number of Medicaid nursing home residents decreased by about 200 people between October 2005 and June 2008. Again, note that reductions in the number of licensed nursing home beds contribute to this decrease.

The number of private pay residents in June 2008 was about the same as in October 2005. Long term care Medicaid financial eligibility requirements have become more rigorous in recent years, which would tend to increase the number of nursing home residents who pay privately. However, if more people are paying privately for home and community-based services, this would tend to decrease the number of nursing home residents who pay privately.

The number of Medicare residents increased by about 40 people between October 2005 and March 2008. A seasonal pattern in the number of Medicare residents appears to exist, with higher numbers in the late winter and spring. The data suggests an inverse relationship between the numbers of Medicare and Medicaid residents: as the number of Medicare residents increases, the number of Medicaid residents tends to decrease; as the number of Medicare residents decreases, the number of Medicaid residents tends to increase.

## Choices for Care Case Management by Area Agencies on Aging and Home Health Agencies

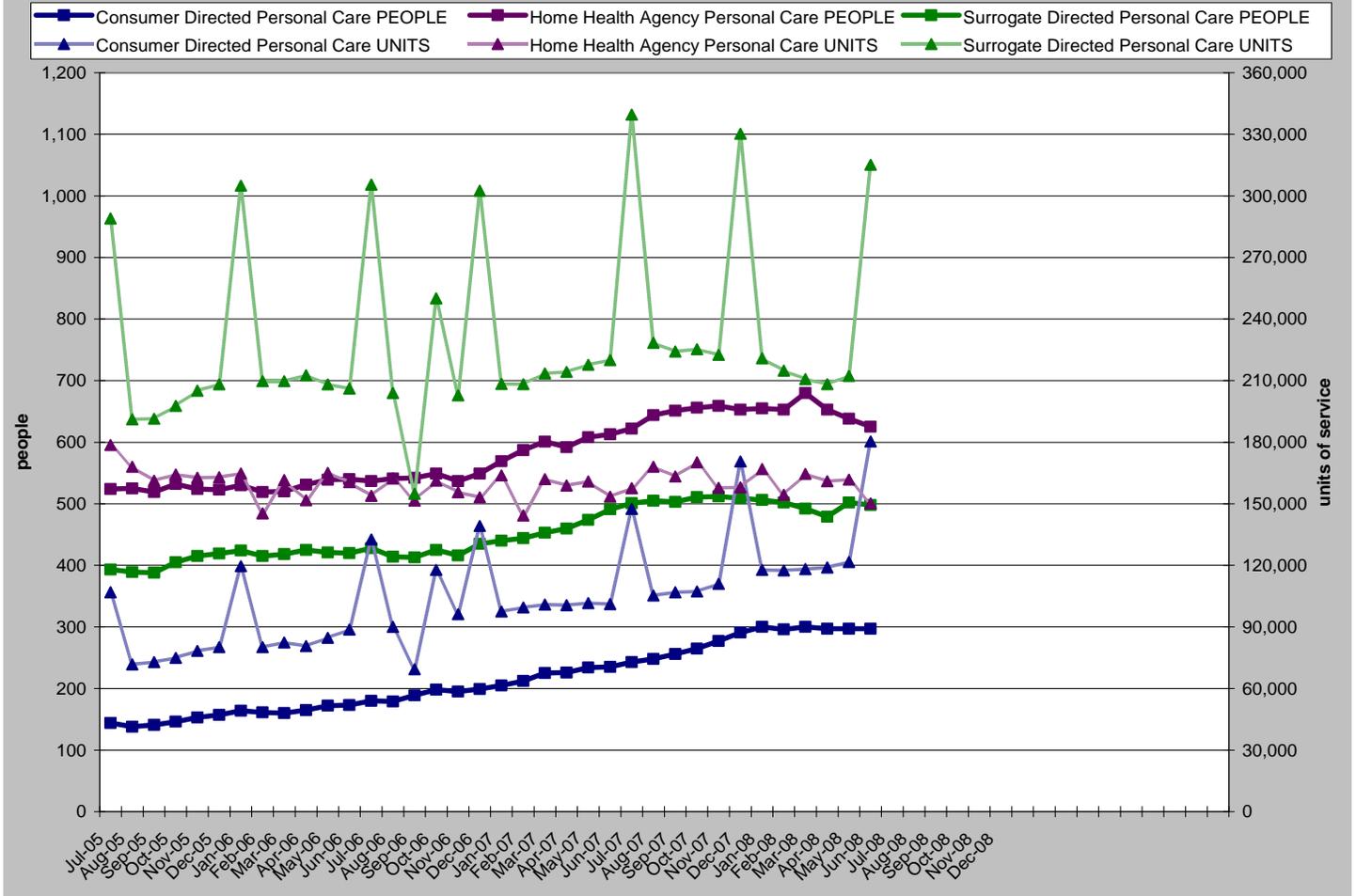


Data source: EDS paid claims, by date of service

CFC case management services are provided by two types of provider agencies: area agencies on aging and home health agencies. This shows the number of people who received case management from each type of agency, and the payments made to each type of agency.

Area agencies on aging continue to provide case management to a larger number of people, but the number of people receiving case management from home health agencies is increasing at a faster rate.

## Choices for Care Personal Care Services by Type



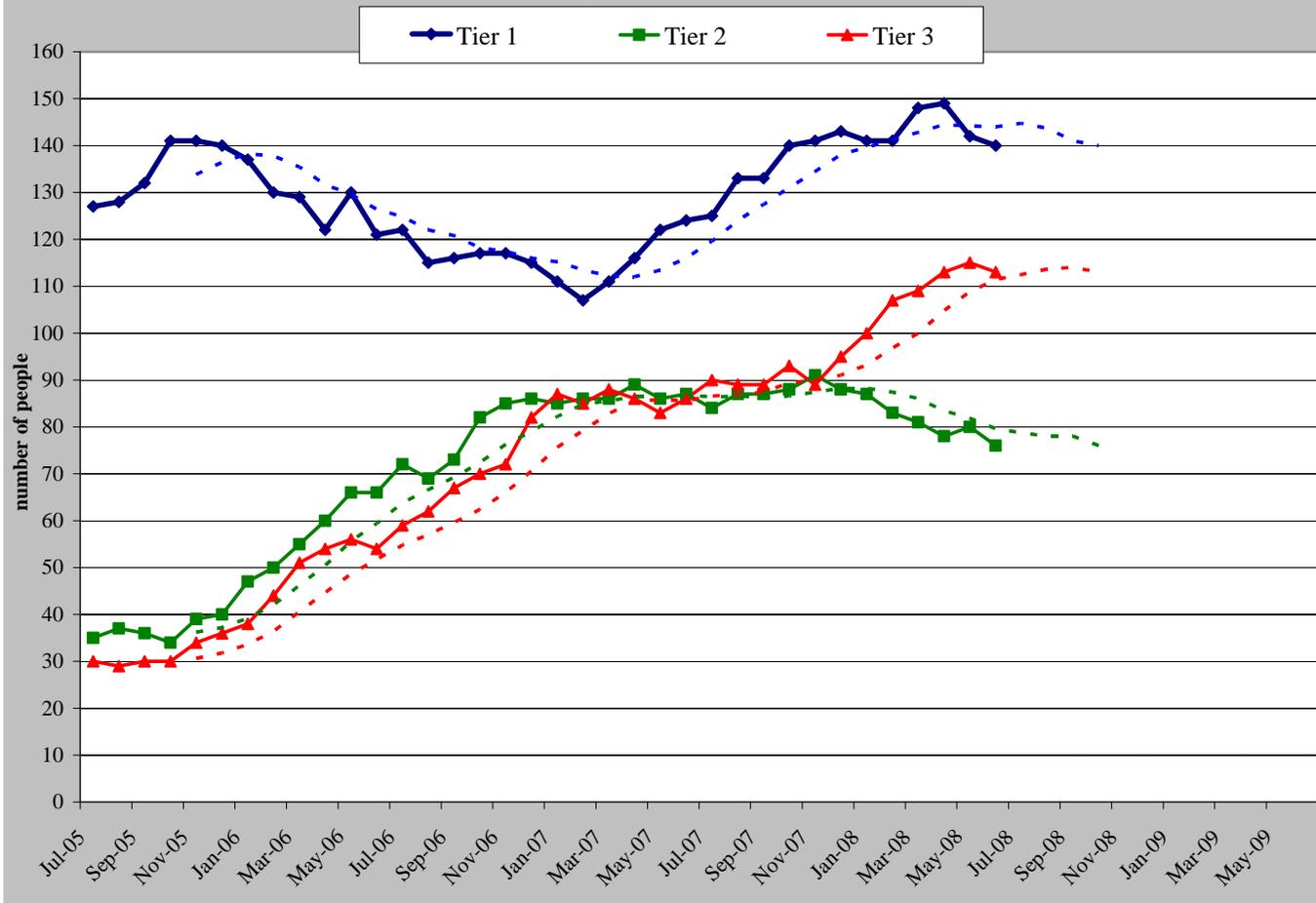
Data source: EDS paid claims, by date of service

This graph shows recent trends in paid Medicaid claims for the three 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 significantly. The number of people using consumer-directed services has increased at the fastest rate. The numbers of people using home health services and surrogate-directed services have increased at a slower, similar rate. (Note that the ‘spikes’ in data for consumer and surrogate directed services are caused by a larger number of payroll periods in some months.)

Together, more people use consumer and surrogate directed services than use home health agency services.

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

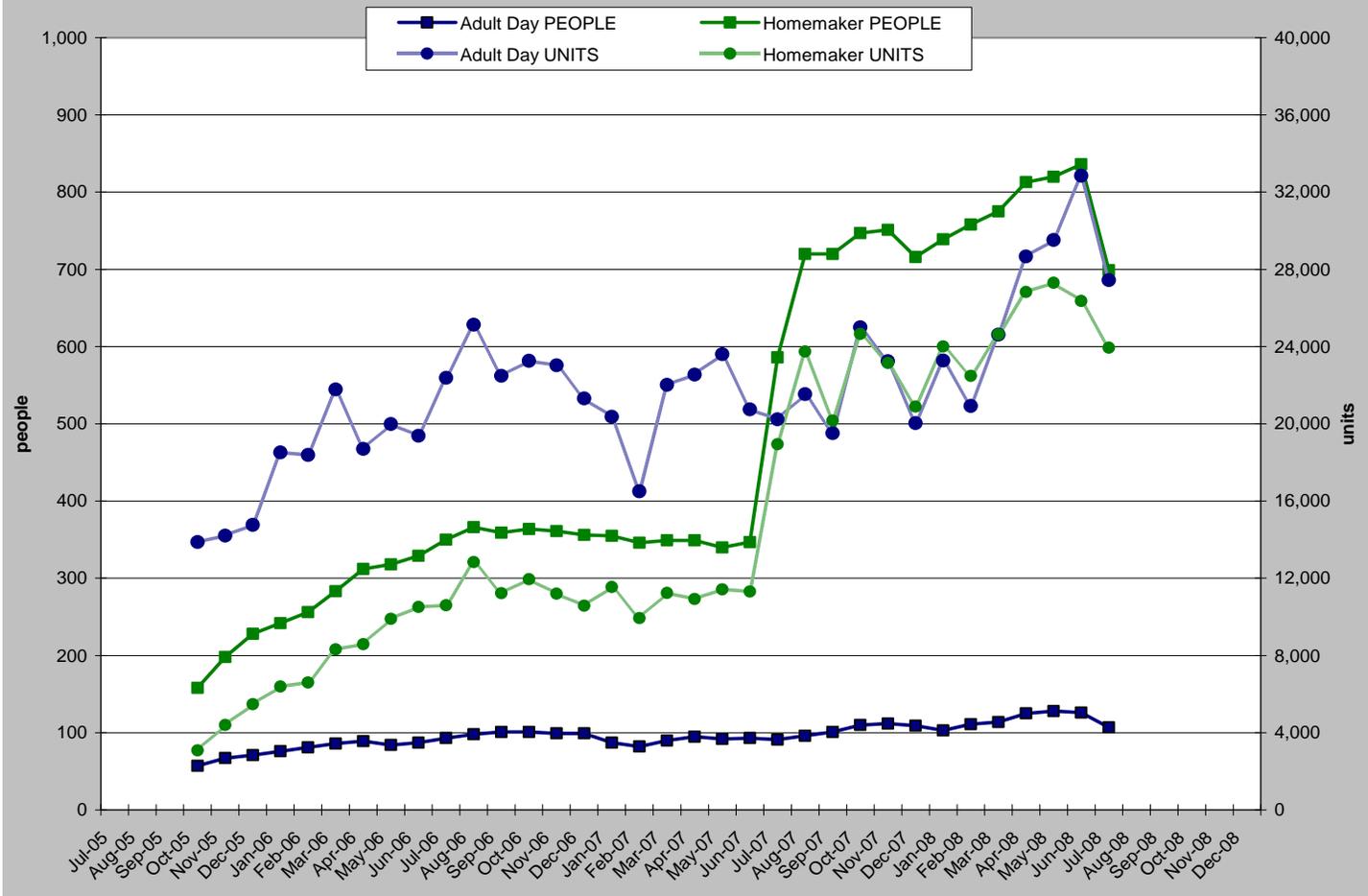


Data source: EDS paid claims, by date of service

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.

In the past three years of Choices for Care, the number of people ‘in’ Tier 3 has increased dramatically- from about 30 people to about 110 people. The number of people in Tier 2 increased for the first year, and has remained fairly stable since then. The number of people in Tier 1 slowly decreased in the first 18 months, and has slowly increased since then.

## Choices for Care Moderate Needs Group Services



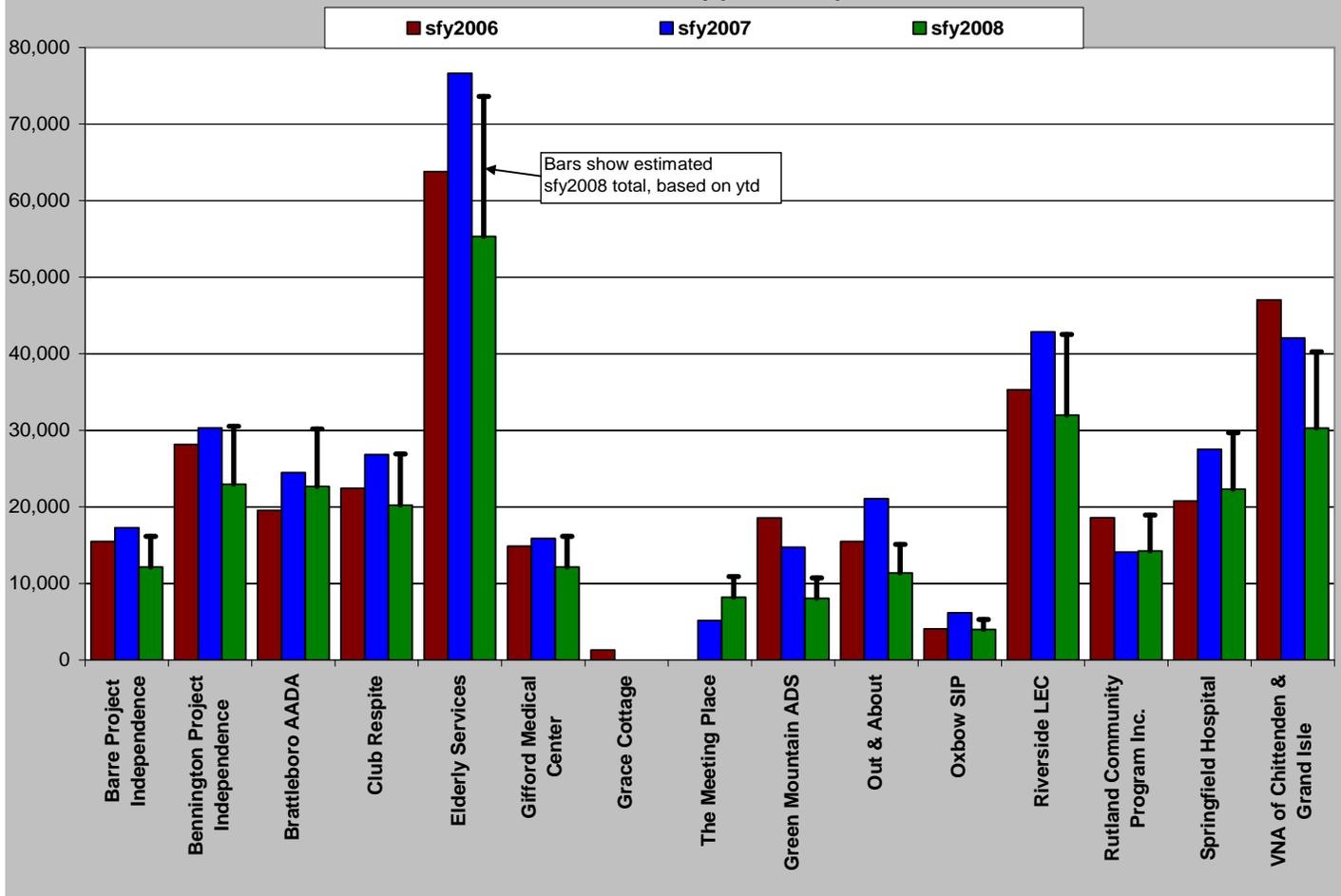
Data source: EDS paid claims, by date of service

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.

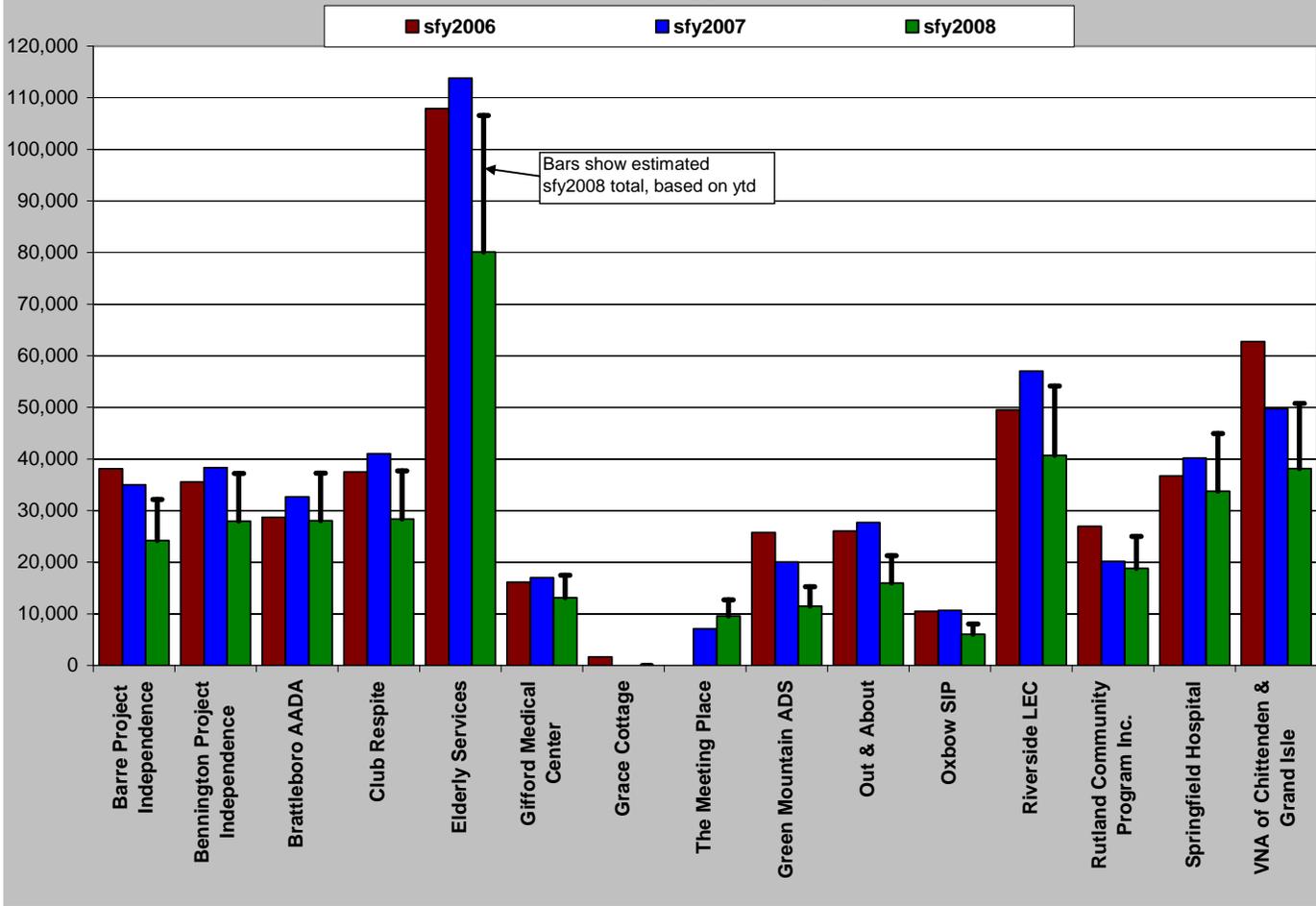
**Waiver, CFC and DHRs Adult Day Service Units by Provider, SFY2006-SFY2008**  
*(sfy2008 represents three quarters)*  
*data source: adult Day provider reports*



*Data source: Adult Day provider reports*

Most adult day providers provided more hours of DAIL-funded services in SFY2007 than in SFY2006. However, the available data suggests that many providers will provide fewer hours of DAIL-funded services in SFY2008 than in SFY2007.

**Total Adult Day Service Units by Provider, SFY2006-SFY2008**  
 (sfy2008 represents three quarters)  
 data source: adult Day provider reports

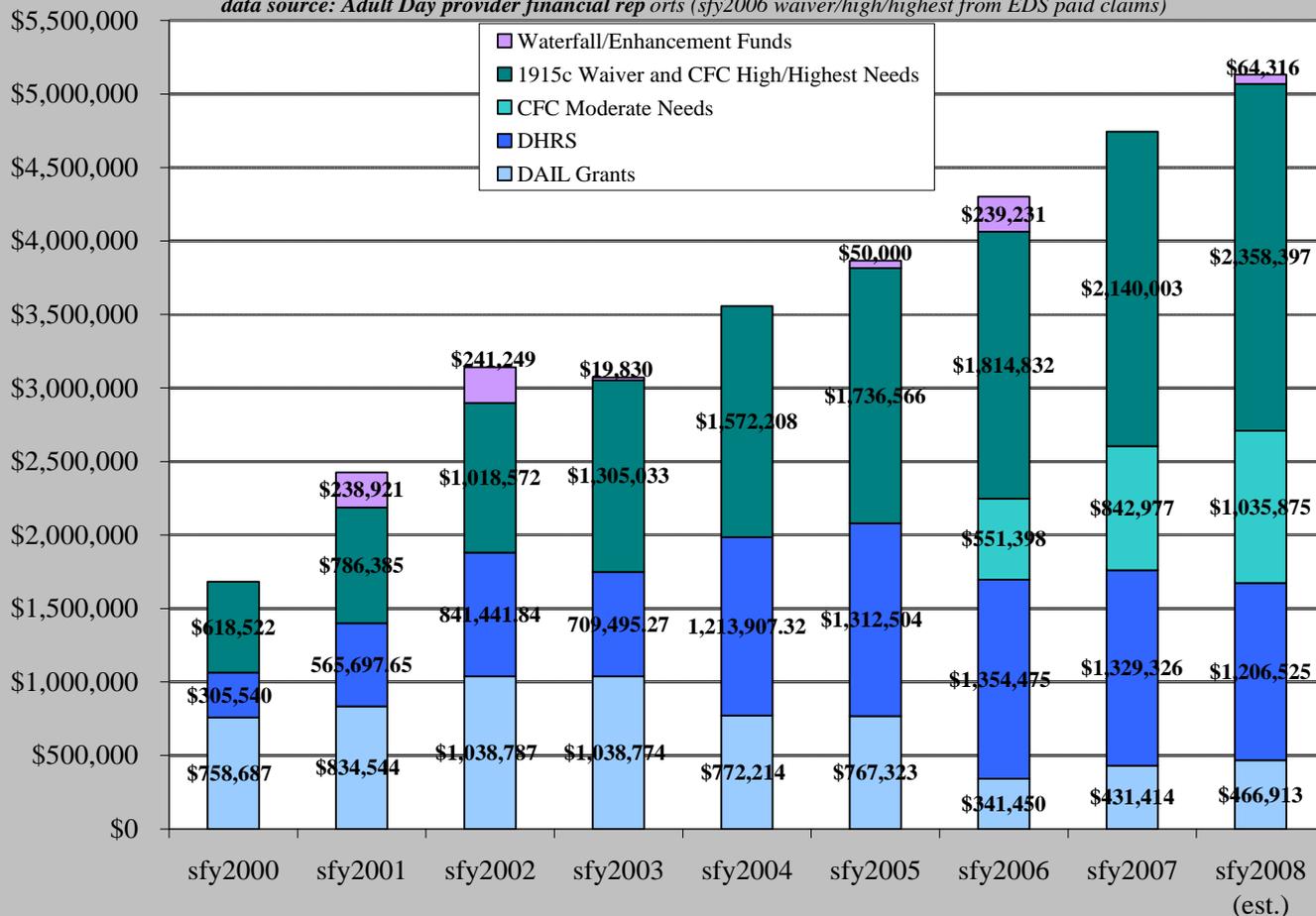


Data source: Adult Day provider reports

Including all funding sources, year-to-date service data suggests that many providers will provide fewer hours of service in SFY2008. This differs from the trend of recent years, when hours of service increased.

### DAIL Adult Day Funding, SFY2000-SFY2008

*data source: Adult Day provider financial reports (sfy2006 waiver/high/highest from EDS paid claims)*



*Data source: Adult Day provider financial reports, via DAIL business office; EDS paid claims*

DAIL funding for adult day services has increased significantly over the past eight years. Funding in SFY2008 was nearly \$1.3 million higher than in SFY2005, an increase of nearly 33%. This increase is due to a combination of increased funding, increased reimbursement rates, expanded Medicaid eligibility through Choices for Care, and more hours of service being provided.

In spite of increased DAIL funding, some adult day providers face financial challenges. Decreases in service hours in SFY2008 would result in less revenue. Increased energy and transportation costs are likely to present additional challenges in SFY2009.