Report of the Vermont State Auditor

April 12, 2012

CHOICES FOR CARE

Desired Outcomes Established, but Evaluation of Actual Results Incomplete

Thomas M. Salmon, CPA, CFE
Vermont State Auditor
Rpt. No. 12-4

Mission Statement

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THOMAS M. SALMON, CPA, CFE
STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

April 12, 2012

Addressees (see next page)

Dear Colleagues,

Since 2005, Vermonters who need long term care and meet certain financial and clinical criteria have been relying on the state's Choices for Care (CFC) program, which is principally managed by the Department of Disabilities, Aging and Independent Living (DAIL). CFC serves a vulnerable population—its participants are elderly and/or physically disabled adults—therefore it is important that an effective performance measurement framework be established to assess the extent to which the program is successful.

Pursuant to Act 63 (2011), this report evaluates whether and how DAIL could more effectively use performance measurement to evaluate the success of the CFC program. We found that the CFC evaluation plan contained desired outcomes, evaluation questions, and performance indicators that generally provide an effective performance measurement framework. However, actual results have not been reported for almost half of the CFC performance indicators and targets (desired results stated in numerical terms) were not included in the evaluation plan. The lack of comprehensive analyses of actual results against targets limits the extent to which CFC can be assessed as a whole. Accordingly, we made several recommendations intended to improve how DAIL evaluates the success of CFC.

I would like to thank the management and staff of DAIL for their cooperation and professionalism. If you would like to discuss any of the issues raised by this audit, I can be reached at (802) 828-2281 or at auditor@state.vt.us.

Sincerely,

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State Auditor

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Introduction

Millions of Americans depend upon long-term care services and supports[1] and the demand for such services are expected to grow. Medicaid[2] is the nation's primary payer of long-term care services and supports. Services for individuals who need long-term care can be very expensive. According to the Kaiser Commission on Medicaid and the Uninsured, in federal fiscal year 2007, Medicaid long-term care users accounted for six percent of the Medicaid population, but nearly half of total Medicaid spending ($144.7 billion in 2007, of which 23 percent was for acute-care services and 77 percent for long-term care services).

Since 2005, Vermonters who need long-term care and meet the financial and clinical criteria have been relying on the state's long-term care Medicaid program, Choices for Care (CFC), which is principally managed by the Department of Disabilities, Aging and Independent Living (DAIL).[3] CFC brought the entire continuum of long-term care settings and services—nursing facilities and home- and community-based services—under a single umbrella. Vermont's CFC expenditures for state fiscal year 2011 were about $192 million[4] (about $205 million was appropriated for fiscal year 2012).

Act 63 (2011) called on the State Auditor's Office to report on how to evaluate the success of CFC. Pursuant to Act 63, our audit objective was to determine whether and how DAIL could more effectively use performance measurement to evaluate the success of the Choices for Care program.

Appendix I contains the scope and methodology we used to address this objective. Appendix II contains a list of abbreviations used in this report.

[1]Long-term care covers a wide range of services, from 24-hour care in nursing facilities to a few hours a week in home-based care assisting with activities such as dressing and housekeeping.

[2]Medicaid is a joint federal/state program. Individuals must meet financial and clinical criteria in order to obtain Medicaid long-term care services. Medicaid is also the safety net for long-term care services for those who become impoverished as a result of disabling illness or injury.

[3]The Department of Vermont Health Access and Department for Children and Families also have responsibilities related to CFC.

[4]The state funded about $64 million of this amount, with the rest being provided by the federal government.

Highlights: Report of the Vermont State Auditor

Choices for Care: Desired Outcomes Established, but Evaluation of Actual Results Incomplete

(April 12, 2012, Rpt. No. 12-4)

Why We Did This Audit

Pursuant to Act 63 (2011), our audit objective was to determine whether and how DAIL could more effectively use performance measurement to evaluate the success of the Choices for Care program.

What We Recommend

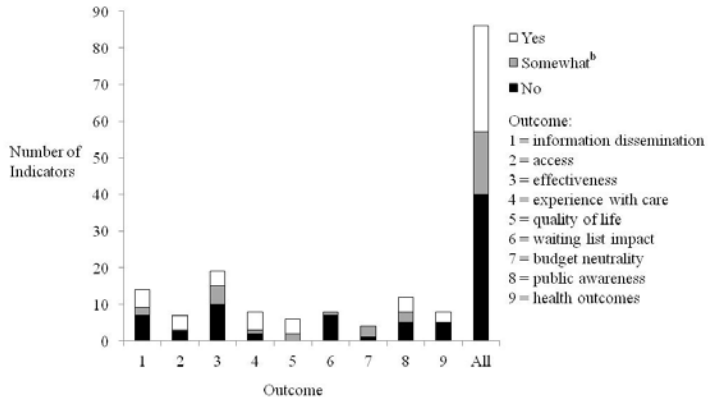
We made a variety of recommendations to the commissioner of DAIL. For example, we recommend that DAIL establish a mechanism to include the feedback of CFC participants that reside in nursing facilities and enhanced residential care settings, ensure that actual results are tracked and reported for all performance indicators in the CFC evaluation plan, and develop targets against which actual results are compared.

Findings

The desired outcomes, evaluation questions, and performance indicators adopted by DAIL for the CFC program generally provide a basis for an effective performance measurement framework. However, the partial reporting of actual results limits its usefulness in evaluating the program's success. DAIL contracted with the University of Massachusetts Medical School (UMMS) to be its independent evaluator of CFC. UMMS' 2008 CFC evaluation plan listed nine desired outcomes: (1) information dissemination, (2) access, (3) effectiveness, (4) experience with care, (5) quality of life, (6) impact of waiting list (also called an applicant list), (7) budget neutrality, (8) public awareness, and (9) health outcomes. These outcomes largely support the expectations and evaluation and monitoring requirements of the CFC program.

Each outcome includes a series of performance indicators, but actual results were not reported in CFC evaluation reports for almost half of the indicators (see figure 1).

Figure 1: Summary of the Extent to Which Actual Results Were Reported for CFC Performance Indicators, by Desired Outcome[a]



[a]A few indicators were included in multiple outcome areas and are counted more than once.

[b]The somewhat category includes those indicators in the evaluation reports that (1) were similar, but not the same as those of the evaluation plan (e.g., numbers rather than percentages or not all settings included), (2) were not evaluated in all years, or (3) both.

DAIL and UMMS reported actual results related to the number of CFC participants that live in a nursing facility versus the number that live in home or community-based settings, showing the extent to which the desired balance between these two settings is being achieved. However, in other cases actual results were not reported or were reported sparingly. For example, DAIL did not obtain feedback about CFC participants that reside in nursing facilities and enhanced residential care settings—about 60 percent of participants. It appears that actual results were not always reported because evaluation reports were weighted toward analyzing the results of surveys of CFC participants using certain home-based services and the use of a more limited set of data sources than originally intended. The CFC evaluation plan also did not include targets (i.e., desired results stated numerically) to provide context for the actual results reported. The lack of complete analyses of actual results against targets limits the extent to which the success of CFC can be assessed as a whole.

Background

CFC is a Medicaid demonstration project, which allows Vermont to run its long-term care program with more flexibility than would be otherwise available under federal rules. As a demonstration program, CFC is required to be evaluated and DAIL uses an independent contractor to perform this function.

Choices for Care Waiver

In 2003, Vermont applied to the federal Centers for Medicare and Medicaid Services (CMS) for a Medicaid long-term care demonstration waiver (also called a section 1115 waiver after the authorizing section of the Social Security Act). Demonstration waivers allow a state to use federal funds in a way not otherwise allowed under federal rules. They provide a way for states to utilize innovative solutions. In June 2005, CMS approved Vermont's long-term care demonstration waiver (CFC) for five years (the current CFC waiver period is October 1, 2005, to September 30, 2015, after an extension request was granted).

CFC serves a vulnerable population—its participants are elderly and/or physically disabled adults[5] that meet certain clinical criteria. CFC established three levels of need for long-term services and supports—highest need, high need, and moderate need.

- *Highest need group.* Individuals are placed in the highest need group if they meet (1) the long-term care Medicaid financial eligibility criteria and (2) specific clinical criteria, such as the need for extensive or total assistance with toileting, eating, bed mobility or transferring, or exhibit severe cognition impairments or certain behaviors.[6] Individuals in this group are entitled to either nursing facility or home and community-based services (HCBS) care. As of February 1, 2012, there were 3,198 individuals in the highest need group.

- *High need group.* As with the highest need group, individuals in the high need group must meet the long-term care Medicaid financial

[5]Exceptions are made for a small number of individuals under the age of 18 who need nursing facility services.

[6]The Department for Children and Families determines the financial eligibility of CFC applicants while DAIL determines their clinical eligibility.

eligibility criteria. In addition, this group consists of individuals whose functional limitations make them eligible for nursing facility care, but they do not meet the level of care criteria for the highest need group. Individuals in this group are entitled to either nursing facility or HCBS care, but are only served to the extent funds are available (i.e., they can be placed on a waiting list). This group was created as a financial safety valve to allow the state to expand the HCBS entitlement for highest need individuals while managing growth. As of February 1, 2012, there were 663 individuals in the high need group and there was no one on the waiting list.

- *Moderate need group.* This is an expansion population[7] of individuals who do not meet the current long-term Medicaid financial and/or clinical criteria, but have unmet needs that put them at risk. Individuals in this group are served to the extent funds are available after serving all eligible individuals in the highest and high need groups.[8] In addition, they can only access a limited number of HCBS services. As of February 1, 2012, there were 981 individuals in the moderate need group.

Appendix III contains a description of the services offered under the CFC program and which ones each need group can access.

UMMS Evaluation

Because Medicaid demonstration waivers are expected to test and learn about new approaches to program design and administration, they are required to be formally evaluated. Since 2007, DAIL has contracted with UMMS to provide independent evaluative services for the CFC program.

A major UMMS deliverable was a CFC evaluation plan issued in October 2008.[9] Prior to this plan being finalized, UMMS sought feedback on its core components from DAIL staff members, national long-term care experts, and key consumer representatives during a two-day roundtable meeting. Subsequent to the roundtable meeting, UMMS gathered additional feedback

[7]An expansion population refers to beneficiaries who cannot be covered under a Medicaid state plan and who can only be covered through the Secretary of the Department of Health and Human Services' authority under section 1115 of the Social Security Act.

[8]According to the CFC waiver's Special Terms and Conditions of Approval, the state is to reserve a minimum of $1.7 million per year for provision of services to the moderate need group.

[9]*Vermont Choice[sic] for Care Final Evaluation Plan* (UMMS, October 2008).

from providers and the DAIL Advisory Board.[10] UMMS has also issued evaluation reports, policy briefs on various topics (e.g., CFC eligibility, hospital discharge planning), and other evaluation documents, such as a CFC qualitative analysis. These documents are generally posted on DAIL's website.[11]

CFC's Outcomes and Performance Indicators Generally Provide the Basis for Effective Performance Measurement, but Partial Reporting of Actual Results Limits Usefulness

DAIL adopted a series of desired outcomes, evaluation questions, and performance indicators for the CFC program that generally provide it with the basis for an effective performance measurement framework. However, the usefulness of this framework in evaluating the success of the CFC program is limited by the partial reporting of actual results. The nine desired outcomes in the evaluation plan largely address the program expectations and evaluation and monitoring requirements laid out in DAIL's request for an extension of the CFC waiver period and subsequent Special Terms and Conditions of Approval, respectively. However, actual results for almost half of the 86 performance indicators in the plan have not been reported. Without actual results for the performance indicators in the plan, DAIL cannot fully assess the extent to which the CFC program has been successful and is more limited in its ability to identify performance gaps. DAIL's ability to evaluate the success of CFC is also hindered by the lack of targets (i.e., desired results stated in numerical terms), which is an element of a well-rounded performance measurement system.

Desired Outcomes Largely Address Program Expectations and Requirements

The CFC performance measurement framework is outlined in the 2008 UMMS CFC evaluation plan. This plan identified nine desired outcomes. Each of these outcomes has at least one evaluation question and supporting performance indicators. DAIL has identified this document as containing the primary performance measurement framework for CFC. This is consistent

[10] 33 VSA §505 established the DAIL Advisory Board, which is responsible for advising the commissioner on matters related to the interests of older persons and persons with disabilities.

[11] http://ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-rpts-consumer-surveys.

with DAIL's reference to this plan in the quality and program evaluation section in its request to CMS for an extension of the CFC waiver period.

The following defines the nine CFC desired outcomes. The first seven outcomes were expected to be achievable in the first 5 years of the demonstration while the last two outcomes were expected to take a longer time to achieve (over 5 years).

Outcome 1: Information Dissemination

Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need.

Outcome 2: Access

Participants have timely access to long-term supports in the setting of their choice.

Outcome 3: Effectiveness

Participants receive effective home- and community-based services to enable them to live longer in the community.

Outcome 4: Experience with Care

Participants have positive experiences with the types, scope, and amount of CFC services.

Outcome 5: Quality of Life

Participants report that their quality of life improves.

Outcome 6: Waiting List (also called applicant list) Impact

CFC applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice, such as nursing facilities, enhanced residential care (ERC) settings,[12] and home care.

Outcome 7: Budget Neutrality

Medicaid's cost of serving CFC participants is equal to or less than under the previous Medicaid and HCBS waiver funding.

[12]An ERC can be either a level III residential care home or an assisted living facility.

Outcome 8: Public Awareness

The Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and individuals have enough information to make decisions regarding long-term care.

Outcome 9: Health Outcomes

CFC participants' medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed.

We compared the CFC evaluation framework (i.e., outcomes supported by evaluation questions and performance indicators) to the expectations for the program, as outlined in the section labeled "Program Objectives" in DAIL's June 2010 waiver extension application to CMS, which contains statements variously labeled as the goal, objectives, and intentions of the program. These statements are not explicitly linked to the outcomes contained in the evaluation plan. However, as shown by table 1, the outcomes in the plan address the expectation statements in the extension application.

Table 1: Program Expectations versus the Outcomes in the Evaluation Plan

Expectation Statement	Covered by Outcomes?[a]
The goal of CFC is to provide Vermonters with individual choice and equal access to long-term care options in the community and nursing facilities.	Yes
The objective of CFC is to increase access to home and community-based services.	Yes
The objective of CFC is to expand the range of community-based service options.	Yes
The objective of CFC is to provide elders and adults with physical disabilities who are at potential risk of future nursing facility placement with early intervention services.	Yes
By offering a range of innovative service options and earlier intervention, Vermont intends to ensure enrollee satisfaction with the long-term care services received.	Yes
By offering a range of innovative service options and earlier intervention, Vermont intends to reduce utilization of institutional care.	Yes
By offering a range of innovative service options and earlier intervention, Vermont intends to control overall costs of long-term care.	Yes

[a]The nine CFC outcomes' supporting evaluation questions and performance indicators were considered as part of this analysis.

We also compared the CFC evaluation framework to the evaluation and monitoring requirements in the waiver's original and current Special Terms and Conditions of Approval. Table 2 shows that the outcomes in the

evaluation plan supports some, but not all, of the requirements of the terms and conditions.

Table 2: Evaluation and Monitoring Requirements in the Waiver's Special Terms and Conditions of Approval versus the Outcomes in the Evaluation Plan

Evaluation and Monitoring Requirement	Covered by Outcomes?[a]			Comment
	Yes	Somewhat	No	
Identify a set of measures that may be the best predictors of individuals at risk for institutional placement.			X	DAIL officials indicated that addressing this requirement was hampered by a lack of funding.
Determine the cost effectiveness of the overall long-term care program to furnish a comprehensive package of home- and community-based services to individuals, based on their specific needs, as compared to the current system.	X			
Assess the effect of CFC on delaying the need for nursing facility care.	X			
Determine the effect of CFC and its policies on participant satisfaction.		X		The performance indicators supporting the quality of life outcome do not include CFC participants that reside in nursing facilities and ERCs.
Determine the effect of CFC and its policies on the array and amounts of services available in the community.			X	
Determine the effect of CFC and its policies on nursing facility census and acuity levels.	X			
Determine the effect of CFC on the level of knowledge in the community with respect to long-term care resources, including Medicaid.		X		The performance indicators supporting the public awareness outcome do not include obtaining feedback from the general public as a whole and most of the quantitative indicators in this outcome do not include CFC participants that reside in nursing facilities and ERCs.

[a]The nine CFC outcomes' supporting evaluation questions and performance indicators were considered as part of this analysis.

In discussions with DAIL management, they pointed out that one option open to them with regards to the evaluation and monitoring requirements that are not covered by the CFC evaluation plan would be to seek an amendment to the waiver's Special Terms and Conditions of Approval to remove these requirements.

Lastly, we considered whether the CFC evaluation framework addresses the relevant outcome set forth by the Legislature. Specifically, Act 146 (2010) specifies outcomes for the Agency of Human Services, the parent agency of DAIL. The outcome in this act relevant to the CFC program states "elders, people with disabilities … live with dignity and independence in the settings they prefer."[13] The outcomes (including supporting evaluation questions and performance indicators) in the CFC evaluation plan encompass elements of this legislative outcome. However, as noted in table 2, the performance indicators supporting the quality of life outcome do not include CFC participants that reside in nursing facilities and ERCs. Accordingly, the indicators in this outcome that address participant independence (e.g., increase in the percentage of participants that respond that they can get around as much as they need) were not applied in the plan to participants that reside in nursing facilities and ERCs.

Analysis of Actual Performance Incomplete

Each desired outcome in the CFC evaluation plan contains a series of performance indicators (categorized as process or outcome indicators). According to DAIL's CFC waiver extension application, the indicators in the evaluation plan "serve as discrete markers for DAIL to immediately monitor and discern whether or the degree to which desirable changes are occurring." In addition, UMMS' evaluation plan stated that the CFC performance indicators were to guide the annual CFC evaluation reporting.

UMMS has issued four evaluation reports covering the first six years of the program[14] and other documents that contain actual results related to the performance indicators in the plan. However, as shown by figure 2, these documents do not contain actual results for almost half of the performance indicators in the evaluation plan (40 of 86 indicators[15]).[16] A more detailed summary of the extent to which actual results have been reported can be

[13]This outcome also includes individuals with mental health conditions. CFC does not include this population except to the effect that the individuals meet the CFC clinical eligibility criteria.

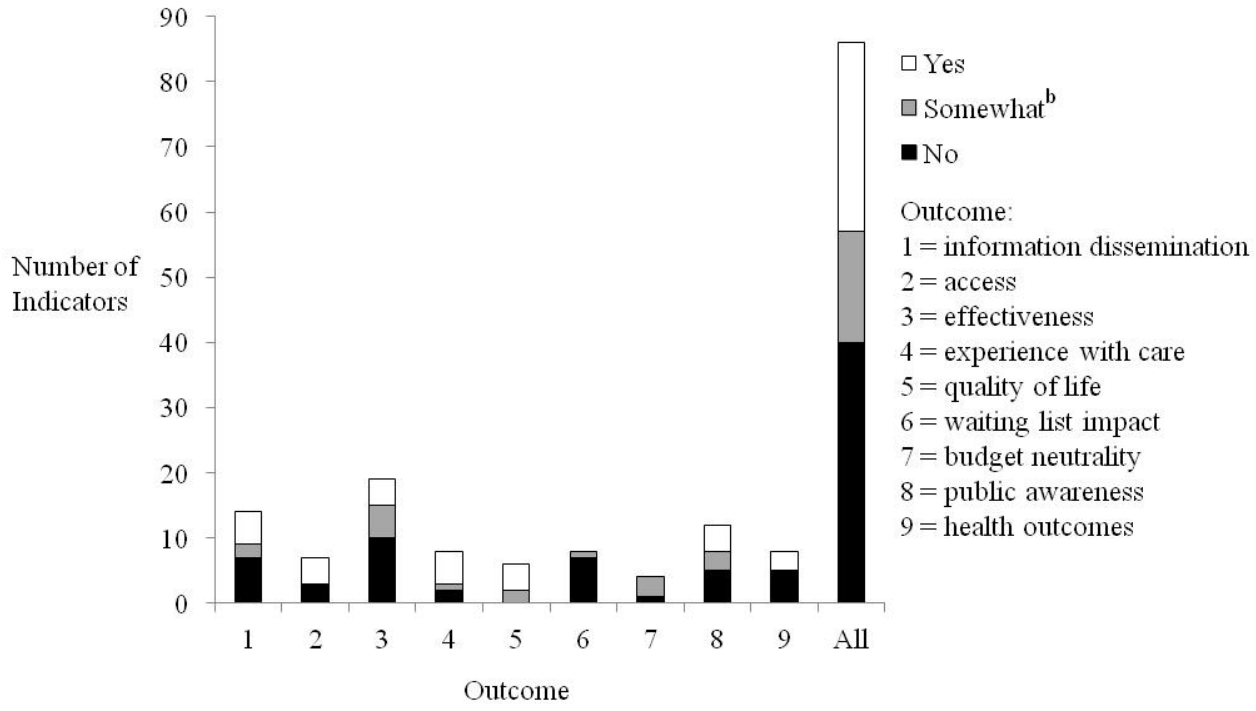
[14]*Vermont Choices for Care: Evaluation of Years 1-3* (UMMS, October 2009); *Vermont Choices for Care: Evaluation of Years 1-4* (UMMS, Summer 2010); *Vermont Choices for Care: Evaluation of Years 1-5* (UMMS, June 2011); *Vermont Choices for Care: Evaluation of Years 1-6* (UMMS, March 2012).

[15]A few indicators were included in multiple outcome areas and are counted more than once.

[16]Our analysis considered the results contained in all of the UMMS documents, not just those formally labeled as an evaluation report. These other documents contained qualitative analyses related to the process indicators in the evaluation plan. Accordingly, unless specifically noted, the use of the term "evaluation reports" indicates all of the UMMS evaluation documents.

found in appendix IV. Without actual results for the performance indicators in the plan, DAIL cannot fully assess the extent to which the CFC program has been successful and is more limited in its ability to identify performance gaps.

Figure 2: Summary of the Extent to Which Actual Results Were Reported for CFC Performance Indicators, by Desired Outcome[a]



[a]A few indicators were included in multiple outcome areas and are counted more than once.
[b]The somewhat category includes those indicators in the evaluation reports that (1) were similar, but not the same as those of the evaluation plan (e.g., numbers rather than percentages or not all settings included), (2) were not evaluated in all years, or (3) both.

Performance Indicators in which Actual Results Were Reported

A national trend in Medicaid is to reduce its bias towards institutional care and shift long-term care resources from nursing facilities to HCBS.[17] From the outset, a major focus of the CFC program has been to "rebalance" Vermont's long-term care resources from nursing facilities to HCBS. A widely used measure to compare Medicaid HCBS access among states is the percentage of HCBS participants compared to total long-term care

[17]This bias is because nursing facility care has traditionally been a mandatory benefit while states generally have had to obtain a waiver to provide HCBS.

participants. Other states also use this or a like measure in evaluating their own long-term care programs. DAIL (and UMMS) report on a comparable measure, the number of CFC participants that live in a nursing facility versus those who live in home- or community-based settings (in total and by county).

Consistent with this emphasis on the use of HCBS, a little more than half of the performance indicators that have been consistently tracked and reported by the UMMS evaluation reports stem from surveys of CFC participants who utilize the HCBS attendant services, personal care services, homemaker services, flexible choices, and adult day programs. These surveys have been performed annually since 2006. UMMS uses them as part of assessing the information dissemination, access, effectiveness, experience with care, quality of life, public awareness, and health outcomes.

In addition to quantitative indicators, the UMMS evaluation plan includes several qualitative performance indicators. These indicators address a variety of process topics, such as DAIL's efforts to strengthen long-term care options education and the state's initiatives to improve the timeliness and user-friendliness of the CFC financial eligibility process. In addition to qualitative analyses in its annual evaluation reports, UMMS issued a qualitative analysis of CFC in August 2008[18] as well as a series of policy briefs and other documents since January 2008.[19] Taken together, these documents provide at least a partial evaluation of most of the qualitative indicators in the evaluation plan.

Areas in which Actual Results were not Reported

Actual results were not reported for almost half of the CFC performance indicators. The following are major participant groups and evaluation areas in which actual results were not reported or were reported sparingly in desired outcome areas that were expected to be achievable in the first five years of the demonstration (October 1, 2005 to September 30, 2010). Without this data, it is not possible to fully evaluate whether the desired short-term

[18] *Choices for Care Evaluation: Qualitative Data Analysis* (UMMS, August 2008).

[19] For example, *Vermont Choices for Care Policy Brief: Eligibility* (UMMS, January 2008); *Vermont Choices for Care Policy Brief: Enrollment and Waiting List* (UMMS, October 2008); *Vermont Choices for Care Policy Brief: Quality Oversight* (UMMS, April 2009); *Vermont Choices for Care Policy Brief: Self-Direction* (UMMS, May 2010); *Vermont Choices for Care Policy Brief: Hospital Discharge Planning* (UMMS, May 2011); and *Vermont Choices for Care: Non-Medical Providers* (January 2012).

outcomes were successfully achieved in the first five years of the CFC waiver period.

- *CFC Participants who Reside in Nursing Facilities and ERCs*. As of February 1, 2012, just over 60 percent of CFC participants resided in nursing facilities or ERCs. The UMMS evaluation reports have very little data related to these participants. Specifically, (1) DAIL did not obtain feedback from these participants as it does for some HCBS participants, (2) actual results pertaining to quantitative indicators were not reported in the information dissemination, access, experience with care, and quality of life outcomes for CFC participants who reside in nursing facilities and ERCs, and (3) the UMMS qualitative analysis report did not address nursing facilities. It may be possible for DAIL/UMMS to obtain feedback about CFC participants who reside in nursing facilities and ERCs through the use of data that is currently collected. For example, DAIL's Division of Licensing and Protection has access to data on nursing facility residents that includes a core set of screening, clinical, and functional status elements (called the Minimum Data Set). Section Q of the Minimum Data Set includes questions about preferences related to returning to the community. This division also conducts interviews and observations related to, for example, the choices, activities, and privacy of nursing facility residents. Moreover, Vermont nursing facilities have administered surveys to current and former residents and family members that solicit feedback on a variety of topics, including quality of care and experiences related to opportunities and choice. This survey instrument is proprietary and it is unclear whether data on CFC participants could be isolated and utilized. The importance of capturing information on participants residing in facilities was noted during a roundtable discussion of a draft of the evaluation plan. According to a summary of this discussion,[20] among the feedback received was "Do not lose sight of Vermont's waiver philosophy to serve participants in the setting of their choice. Measuring outcomes in both nursing facilities and home care settings would capture both setting choices."

- *High Need Group Waiting List Impact*. One of the unique features of CFC was the establishment of the high need group. According to UMMS, no other state had been granted the authority to limit

[20] *Vermont Choices for Care Evaluation: Roundtable Summary* (UMMS, April 2008).

Medicaid coverage of nursing facility care for individuals who meet the clinical criteria for admission (i.e., through a waiting list). The UMMS evaluation reports included actual results related to the number of participants on the high need group waiting list. However, actual results were reported for only one of the indicators associated with the waiting list outcome (outcome 6). For example, actual results were not reported on the (1) percentage of applicants with changes in their activities of daily living or instrumental activities of daily living functionality and (2) number of hospital admissions or emergency room visits following placement on the waiting list. Although there has not been a high need group waiting list since February 2011, in the 75 months between October 2005 and December 2011, there was a waiting list for about three quarters of the time. The frequency of the use of a waiting list over the course of the waiver period thus far indicates the importance of collecting information on the effect of a waiting list on this at-risk population.

- *Delaying or Preventing the Need for Nursing Facility Care*. In its letters approving the original CFC waiver and its extension, CMS noted that the waiver's evaluation component included determining its effect on delaying and preventing the need for nursing facility care. The establishment of the moderate need group in particular was intended to determine whether providing a limited package of HCBS could be a preventive method that delays or avoids institutional care. According to the CFC evaluation plan, the effectiveness outcome is intended to measure the effectiveness of HCBS in increasing the likelihood that individuals will be able to remain longer in the community and therefore reduce nursing facility care. However, actual results were not reported for about half of the performance indicators related to this outcome and others were only partially reported. For example, the evaluation reports did not include actual results for (1) the percentage of participants moving into the high or highest need groups from a lower CFC level of need and (2) the average duration of time from moderate need group enrollment to highest or high need enrollment for those moderate need enrollees who met high need proxy eligibility criteria[21] versus those that did

[21]Moderate need group members do not have to meet the same level of clinical criteria as highest and high need group members. However, a participant could meet the highest or high need clinical criteria, but be a member of the moderate need group because, for example, he or she does not meet the financial eligibility criteria. Proxy eligibility criteria refers to using certain moderate need clinical criteria as a substitute for the highest and high need clinical criteria in order to project whether the participant meets the clinical criteria for these groups.

not. In addition, actual results were not reported for the quantitative performance indicators addressing nursing home acuity.[22] According to the CFC evaluation plan, if community services are effectively supporting participants, they will enter nursing facilities later and at a higher acuity level (as measured by physical and cognitive limitations).

- *Costs of Service Delivery*. The CFC evaluation plan calls for various types of cost reporting. The evaluation reports included some cost data, such as total amount spent on CFC by fiscal year. However, actual results were not consistently reported in the evaluation reports. For example, actual results showing the average cost of approved plans of care compared to average actual cost per person was not reported. In addition, the reporting of actual results related to the average annual CFC expenditures by level of need and setting was limited to HCBS and enhanced residential care expenditures in the first three years of the waiver. Moreover, actual results were not reported on the decrease in the percentage of annual expenditures on nursing facility care versus that provided for HCBS for the highest and high need groups. This type of cost data can provide valuable insight into the use of CFC funding.

With respect to the long-term CFC health outcome (i.e., CFC participants' medical needs are addressed to reduce preventable hospitalization and their long-term care needs are effectively addressed), the results of few indicators have been reported. According to UMMS, understanding CFC's impact on participants' overall health is crucial to understanding whether any important unintended consequences occurred.

The gap between the number of performance indicators in the CFC evaluation plan and the number of indicators for which actual results have been reported appears to stem from two causes. First, the UMMS evaluation reports were weighted toward analyzing and reporting on the results of the consumer survey of selected HCBS participants (a much greater percentage of the actual results reported were from this survey than anticipated in the CFC evaluation plan). The UMMS director of performance improvement stated that its focus on HCBS stemmed from the perception that CFC is mainly focused on allowing participants to be served in the community.

[22]The latest CFC evaluation report issued in March 2012 contained data on the average nursing facility case mix score, which is an acuity indicator. However, this was not one of the four outcome performance indicators of nursing home acuity contained in the CFC evaluation plan.

Second, while the CFC evaluation plan cited a wide variety of data sources that UMMS considered to be readily available (e.g., existing data), there appeared to be a much more limited number of sources used in the evaluation reports. In particular, UMMS has generally relied on data provided by DAIL and does not have access to data in the CFC enrollment systems or Medicaid claims system.

DAIL officials acknowledged that there was a lack of a connection between the evaluation plan and the reporting of actual results and stated that they plan to establish a more linear connection in the future. In addition, in March 2012, UMMS stated that it was time for DAIL and UMMS evaluators to engage in a comprehensive review and revision of the evaluation plan. Accordingly, UMMS recommended revisiting the CFC evaluation framework, including accessing existing data sets related to outcomes and collaborating with state staff involved with nursing facilities to determine appropriate measures for that population. In addition, UMMS suggested that a revised evaluation plan could add specific evaluation activities related to the moderate need group to investigate the characteristics of this group and its progress. In commenting on a draft of this report, the commissioner of DAIL stated that the department plans to work with UMMS to revise the evaluation plan and measures in the state fiscal year 2013 evaluation report.

We believe that there is merit in the UMMS recommendation to revisit the CFC evaluation framework. This would provide the opportunity for UMMS and DAIL to reconsider whether there are additional evaluation areas that could provide insight into the success of the CFC program as well as whether the indicators in the current plan are still relevant.

Appendix V includes examples of performance indicators related to CFC savings and quality of care that are currently not included in the CFC evaluation plan that could be considered in the revision of the plan. We are providing this information for illustrative purposes only because decisions on the use of specific performance indicators are those of management and can hinge on information beyond the scope of this audit, such as whether reliable data is currently available or could be collected without an expensive data collection effort.

Evaluation of CFC Could Benefit From Use of Targets

Our previous performance measurement work identified a number of practices that research showed constituted elements of a well-rounded

performance measurement system.[23] Among these practices are the establishment of targets (i.e., the desired numerical result associated with a performance indicator) and the comparison of targets to actual results.

The UMMS CFC evaluation plan does not include targets. Instead its performance indicators sometimes use the terminology that there is expected to be an increase or decrease in a particular percentage. However, the indicators do not include a baseline with which to judge the increase or decrease (e.g., "from") nor what level the CFC program is trying to achieve (e.g., "to").

The UMMS director of performance improvement indicated that targets were not established because most indicators related to HCBS did not have independent benchmarks against which to judge the actual results. However, targets can be established on other bases, such as historical trends, projections, and comparisons to other states. To illustrate, the state's application and related documents submitted during the request for the original CFC waiver included projections, expectations, and historical trends that could have been used to set targets. For example, the state indicated that it expected to (1) enroll about 1,050 individuals in the moderate need group and (2) improve satisfaction levels beyond 82 percent related to the amount of an individual's choice and control, timeliness of service, and problem and concern resolution.

The usefulness of targets can be shown by DAIL's employment of a target for one notable performance indicator—the number of CFC participants that live in a nursing facility versus those that live in home- or community-based settings (in total and by county). As part of this indicator, DAIL reports on how many participants cause it to be below a target of achieving a balance between nursing facilities and HCBS settings. DAIL originally set a target of achieving a 60 percent/40 percent balance between participants receiving services in nursing facilities and in home- and community-based settings (which includes ERCs), respectively. DAIL has met this target and established a new target of achieving a 50 percent/50 percent balance. By utilizing targets in this instance, DAIL has been able to clearly demonstrate its improvement in achieving an important aim of the CFC program.

[23] *Department of Economic Development and Vermont Economic Progress Council: Enhancements to Performance Measurement Systems Could Be Made* (SAO, September 14, 2009, Report 09-05); *Department of Motor Vehicles: Performance Measurement System Could Be Enhanced* (SAO, July 22, 2009, Report 09-4); *Department of Buildings and General Services* (SAO, June 29, 2009, Report 09-3).

Apart from the 50 percent/50 percent participants residing in nursing facility/home- and community-based settings target, the annual UMMS evaluation reports did not compare actual results to targets. This lack of complete analyses of actual results against targets limits the extent to which the success of CFC as a whole can be judged.

Conclusion

With annual expenditures approaching (and expected to soon exceed) $200 million, the Choices for Care program uses substantial federal and state resources. In addition, this program provides critical services to a vulnerable population. Accordingly, it is important that an effective performance measurement framework be established to assess the extent to which the program is successful—considering various perspectives, including those related to fiscal accountability and participant outcomes. DAIL has adopted a performance framework that includes outcomes, evaluation questions, and performance indicators that could potentially effectively measure the CFC program. However, since actual results were not reported for almost half of the indicators and targets were not established, this potential has not been fulfilled. In particular, feedback has not been sought on more than half of the CFC participants and major evaluation areas have not been assessed. Accordingly, DAIL lacks the information needed to fully assess the extent to which the CFC program has been successful as a whole and may not identify performance gaps that require attention.

Recommendations

We recommend that the commissioner of the Department of Disabilities, Aging and Independent Living

1. Identify a set of indicators that may be the best predictors of individuals at risk for institutional placement, as required by the CFC waiver's Special Terms and Conditions of Approval, or obtain written agreement from CMS to eliminate this requirement from the terms and conditions.

2. Identify a set of indicators to determine the effect of CFC and its policies on the array and amounts of services available in the community, as required by the CFC waiver's Special Terms and

Conditions of Approval, or obtain written agreement from CMS to eliminate this requirement from the terms and conditions.

3. Identify a set of indicators to assess the effect of CFC on the level of knowledge about long-term care resources in the general public, as required by the CFC waiver's Special Terms and Conditions of Approval, or obtain written agreement from CMS to eliminate this requirement from the terms and conditions.

4. Establish a mechanism to include feedback about CFC participants that reside in nursing facilities and ERCs as part of the evaluation of, at a minimum, the information dissemination, access, experience with care, and quality of life outcomes.

5. Ensure that actual results are tracked and reported for all performance indicators in the current CFC evaluation plan or revised CFC evaluation plan should DAIL decide to revisit the plan.

6. Develop targets against which actual results are compared for the performance indicators in the current CFC evaluation plan or revised CFC evaluation plan should DAIL decide to revisit the plan.

Management's Comments and Our Evaluation

The commissioner of DAIL provided comments on a draft of this report dated April 2, 2012 (appendix VI contains a reprint of the comments). DAIL agreed with the recommendations in the report, indicating that it planned to (1) consult with UMMS and/or the DAIL Advisory Board with respect to the recommendations pertaining to the CFC waiver's Special Terms and Conditions of Approval and (2) work with UMMS to revise the CFC evaluation plan and measures in the state fiscal year 2013 evaluation report.

Although DAIL agreed with the recommendations, it disagreed with some of the statements in the finding and conclusion sections of the report. With respect to the finding section, table 2 in the report lists the evaluation and monitoring requirements in the original and current Special Terms and Conditions of Approval of the CFC waiver. One of the requirements is to determine the effect of CFC and its policies on the array and amounts of services available in the community. DAIL commented that it does not agree with the representation that CFC was intended to increase the array of services available to people who are not eligible for or enrolled in CFC. First, the assertion in the table reflects the statements contained in the original and

current Special Terms and Conditions of Approval. Second, the state's 2003 CFC waiver proposal to CMS states that one of CFC's programmatic objectives is to facilitate the "further growth and development of home- and -community based services and resources throughout the state" and includes language similar to that in table 2 in its description of planned evaluation questions for which it intended to seek answers. Third, this comment is inconsistent with DAIL's agreement with our recommendation related to this evaluation and monitoring requirement.

DAIL also disagreed with some of the language in our conclusion, as described in the following points.

- DAIL indicated that it believed that our comment of the importance of having an effective performance framework "from both a fiscal and participant perspective" was a proposal for a framework and, as such, was insufficient. We did not intend that our statement be construed as a proposed framework for CFC nor that fiscal and participant perspectives be the only elements of such a framework. We have clarified this sentence in the conclusion.

- DAIL disagreed with our statement that it lacks the information needed to fully assess the extent to which the CFC program has been successful as a whole. DAIL stated that it believed that it had good evidence of success although it agreed that it could and should have better evidence. DAIL asserted that CFC has succeeded in "what many would consider to be among the most important measures/indicators: more people served overall; more people served in the community; fewer people served in nursing homes; high rates of satisfaction in the community; [and] more service options available and used in the community." As we stated in the report, DAIL has reported actual results in important areas, particularly as it relates to the number of individuals living in nursing facilities versus home- or community-based settings and the results of surveys of participants that utilize certain HCBS programs. Nevertheless, very few results have been reported on the effect of CFC on participants that reside in nursing facilities and ERCs—just over 60 percent of the CFC participants. In addition, limited results were reported related to (1) the impact of the high need group waiting list, (2) whether CFC has an effect on delaying or preventing the need for nursing facility care, and (3) the cost of service delivery. Taken together, these limitations related to the actual results reported coupled with a lack of targets that could be used to judge results, leads us to continue to conclude that

DAIL lacks critical information with which to evaluate the success of the CFC program as a whole.

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In accordance with 32 VSA §163, we are also providing copies of this report to the secretary of the Agency of Administration, commissioner of the Department of Finance and Management, and the Department of Libraries. In addition, the report will be made available at no charge on the state auditor's website, http://auditor.vermont.gov/.

Appendix I

Scope and Methodology

To address our objective we first researched the origins of the Choices for Care program as well as later decisions related to this program. This involved (1) reviewing state laws related to long-term care and Challenges for Change and (2) listening to testimony before various legislative committees by DAIL officials and advocates of long-term care. We also performed research on long-term care issues in general and obtained and reviewed documents from a variety of sources, including CMS, the Kaiser Commission on Medicaid and the Uninsured, the Hilltop Institute, the AARP Foundation, the Commonwealth Fund, and the SCAN Foundation.

To understand the expectations and evaluation and monitoring requirements related to CFC, we considered the original application to the federal government to obtain the waiver and the subsequent Special Terms and Conditions of Approval. We also reviewed DAIL's application to extend the waiver period and the current Special Terms and Conditions of Approval. To assess the completeness of the outcomes of the CFC program, we compared the expectations and evaluation and monitoring requirements in these documents to the evaluation framework contained in the UMMS October 2008 CFC evaluation plan. We also considered the extent to which this framework supported the legislative outcome for elders and the disabled contained in Act 146 (Challenges for Change).

In order to determine the extent to which the CFC evaluation framework was implemented, we obtained copies of all of the UMMS evaluation reports. These documents included four evaluation reports, policy briefs, and various other reports, including a qualitative analysis of CFC. We compared the performance indicators in the CFC evaluation plan to those in the UMMS evaluation reports to assess the extent to which actual results were reported.

We also interviewed officials from DAIL, including the deputy commissioner, the aging and disabilities program manager, and the data and planning unit director. In addition, we attended and participated in a meeting with the DAIL Advisory Board. To more fully understand the UMMS evaluation plan and reports, we contacted and discussed various issues with the UMMS director of performance improvement.

We considered internal controls only to the limited extent to which they related to our objectives. For example, we discussed with a DAIL CFC staff member the process used to approve CFC participants and reviewed applicable documentation. In particular, we reviewed the CFC regulations, operational protocol, participant handbook, application, and clinical eligibility worksheet.

Appendix I

Scope and Methodology

Our audit work was performed between November 2011 and mid-March 2012 and included site visits to DAIL headquarters in Williston. Except for the exception described below, we conducted this performance audit in accordance with generally accepted government auditing standards, which require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The standard that we did not follow requires that our system of quality control for performance audits undergo a peer review every three years. Because of fiscal considerations, we have opted to postpone the peer review of our performance audits. Notwithstanding this exception, we believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II

Abbreviations

CFC	Choices for Care
CMS	Centers for Medicare and Medicaid Services
DAIL	Department of Disabilities, Aging and Independent Living
ERC	Enhanced Residential Care
HCBS	Home- and Community-Based Services
UMMS	University of Massachusetts Medical School

Appendix III

Choices for Care Settings and Services

Table 3: Summary of CFC Settings and Services

CFC Settings/Services	When was Service First Available		Available to Which Groups			# of Participants approved for service (as of 2/22/12)[a]
	Pre-CFC Waiver	Post-CFC Waiver	Highest	High	Moderate	
Nursing facilities: Licensed facilities that provide nursing care and related services for people who need nursing, medical, rehabilitation or other special services.	X		X	X		2013
Enhanced residential care: This is composed of two types of facilities, (1) residential care homes (level III), which are licensed group living arrangements designed to meet the needs of people who cannot live independently and usually do not require the type of care provided in a nursing facility (homes provide nursing overview, but not full-time nursing care) and (2) assisted living facilities, which are licensed residences that combine housing, health, and supportive services.	X		X	X		370
Program for All-Inclusive Care for the Elderly: Combines an individual's Medicare and Medicaid benefits to deliver all health and long-term care services.		X	X	X		114
Case management: Assists in obtaining, coordinating, and monitoring services.	X		X	X	X	100% of people approved for ERC and HCBS
Homemaker services: Services include household chores, such as shopping, cleaning, and laundry.	X		X	X	X	834
Adult day: Adult day services during the daytime include activities, social interaction, nutritious meals, health screening and monitoring, personal care, and transportation.	X		X	X	X	376
Personal care services: Assists with activities of daily living, such as dressing, toileting, and transferring.	X		X	X		1090
Companion services: Supervision and socialization of individuals who are unable to care for themselves.	X		X	X		822
Respite services: Relief from caregiving and supervision for primary caregivers.	X		X	X		267
Personal Emergency Response System: An electronic device that enables a person to secure help in an emergency.	X		X	X		693

Appendix III

Choices for Care Settings and Services

CFC Settings/Services	When was Service First Available		Available to Which Groups			# of Participants approved for service (as of 2/22/12)[a]
	Pre-CFC Waiver	Post-CFC Waiver	Highest	High	Moderate	
Assistive devices/home modifications: Assistive devices are used to increase, maintain, or improve an individual's functional capabilities. Home modifications are physical adaptations to the individual's home that help to ensure the health and welfare of the individual or that improve the individual's ability in performing activities of daily living, instrumental activities of daily living, or both.	X		X	X		222
Intermediary service organization: An organization that provides assistance to individuals with payroll, taxes, and other financial management issues.	X		X	X		706
Flexible choices: Consumers, working with the flexible choices consultant, develop their own package of services tailored to their needs. The content of these services is limited by the amount of the consumer's allowance, program guidelines, and what the individual needs to stay healthy and independent.		X	X	X		99

[a]The numbers in this column are not mutually exclusive because CFC participants can be approved for multiple services (e.g., both adult day and homemaker services).

Appendix IV

Comparison of Extent to which Performance Indicators' Actual Results Were Reported

Table 4: Summary of the Extent to which Actual Results of the Performance Indicators in the CFC Evaluation Plan were Reported

Outcome/Evaluation Question/ Indicator Type	Total Indicators	Actual Performance Reported?			Comment
		Yes	Somewhat[a]	No	
Outcome 1: Information Dissemination					Except for two qualitative process indicators, none of the indicators in the "yes" column pertain to participants that reside in nursing facilities and ERCs.
Evaluation Question 1.1: To what extent did participants receive information to make choices and express preferences regarding services and settings?					
Total Indicators, Outcome 1	**14**	**5**	**2**	**7**	
Outcome 2: Access					Except for two qualitative process indicators, none of the indicators in the "yes" column pertain to participants that reside in nursing facilities and ERCs.
Evaluation Question 2.1: Are new CFC participants or nursing home residents who seek discharge able to receive CFC services in a timely manner?					
Indicators	3	2	0	1	
Evaluation Question 2.2: To what extent are CFC participants receiving the types and amounts of supports consistent with their currently assessed needs?					
Indicators	4	2	0	2	
Total Indicators, Outcome 2	**7**	**4**	**0**	**3**	
Outcome 3: Effectiveness					
Evaluation Question 3.1: Is CFC increasing in its ability to serve participants in all CFC levels of need in the community?					
Indicators	10	4	4	2	
Evaluation Question 3.2: To what extent are participants' long-term care supports coordinated with each other for the purpose of providing effective care?					
Indicators	4	0	0	4	
Evaluation Question 3.3: To what extent did Medicaid nursing facility residents' acuity, as measured by physical and cognitive performance, change over the demonstration period?					
Indicators	5	0	1	4	
Total Indicators, Outcome 3	**19**	**4**	**5**	**10**	

Appendix IV

Comparison of Extent to which Performance Indicators' Actual Results Were Reported

Outcome/Evaluation Question/ Indicator Type	Total Indicators	Actual Performance Reported?			Comment
		Yes	Somewhat[a]	No	
Outcome 4: Experience with Care Evaluation Question 4.1: To what extent do CFC participants report having positive experiences with the types, amount, and scope of CFC services?					Except for one qualitative process indicator, none of the indicators in the "yes" column pertain to participants that reside in nursing facilities and ERCs.
Total Indicators, Outcome 4	**8**	**5**	**1**	**2**	
Outcome 5: Quality of Life Evaluation Question 5.1: To what extent did CFC participants' reported quality of life improve over the demonstration period?					None of the indicators pertain to participants that reside in nursing facilities and ERCs.
Total Indicators, Outcome 5	**6**	**4**	**2**	**0**	
Outcome 6: Impact of Waiting List (also called applicant list) Evaluation Question 6.1: To what extent does the implementation of a waiting list for the high needs group in Choices for Care have different impact on applicants waiting to access HCBS vs. nursing facility services?					
Total Indicators, Outcome 6	**8**	**0**	**1**	**7**	
Outcome 7: Budget Neutrality Evaluation Question 7.1: Were the average annual costs of serving CFC participants less than or equal to the projected annual costs of serving this population in the absence of the waiver?					
Total Indicators Outcome 7	**4**	**0**	**3**	**1**	
Outcome 8: Public Awareness Evaluation Question 8.1: To what extent are Vermont residents who are hospitalized aware of long-term care setting options at the time of discharge?					Except for two qualitative process indicators, none of the indicators in the "yes" column pertain to participants that reside in nursing facilities and ERCs.
Indicators	3	1	1	1	
Evaluation Question 8.2: To what extent are Vermont residents who are hospitalized supported in making decisions regarding how their long-term care needs are met at the time of discharge?					
Indicators	9	3	2	4	
Total Indicators, Outcome 8	**12**	**4**	**3**	**5**	

Appendix IV

Comparison of Extent to which Performance Indicators' Actual Results Were Reported

Outcome/Evaluation Question/ Indicator Type	Total Indicators	Actual Performance Reported?			Comment
		Yes	Somewhat[a]	No	
Outcome 9: Health Outcomes					Except for one qualitative process indicator, none of the indicators in the "yes" column pertain to participants that reside in nursing facilities and ERCs.
Evaluation Question 9.1: To what extent are CFC participants' long-term care needs being effectively addressed?					
Indicators	4	2	0	2	
Evaluation Question 9.2: To what extent are participants' medical needs addressed to reduce preventable hospitalizations?					
Indicators	4	1	0	3	
Total Indicators, Outcome 9	**8**	**3**	**0**	**5**	
Grand Total, All Outcomes	**86**	**29**	**17**	**40**	

[a]The somewhat category includes those indicators in the evaluation reports that (1) were similar, but not the same as those of the evaluation plan (e.g., numbers rather than percentages or not all settings included), (2) were not evaluated in all years, or (3) both.

Appendix V

Potential Areas of Performance Indicators

UMMS has recommended revisiting the CFC evaluation framework. Over the course of this audit, our research showed there were additional performance indicators not currently in the CFC evaluation plan related to savings and quality of care that could provide additional insight into the CFC program. Given UMMS' recommendation, it may be time to consider these other indicators.

We are providing this information for illustrative purposes only. There are various considerations that influence management's choice of performance indicators, including the specific goals that a program is intended to achieve and whether reliable data is currently available or could be collected without an expensive data collection effort in the future. The feasibility of collecting reliable data on specific indicators was beyond the scope of our audit.

Savings

The question of the achievement of "savings" related to CFC has been an issue since prior to the approval of the waiver in 2005. For example, Act 123 (2004), in which the Legislature endorsed the concept of the demonstration waiver, states "any savings realized due to the implementation of the long-term care Medicaid 1115 waiver shall be retained by the department [DAIL] and reinvested into providing home and community-based services."[24] However, the legislature did not define what constitutes "savings." The fiscal year 2008 appropriations act (Act 65) directed DAIL in its budget presentation to

> "include the amount of savings generated from individuals receiving home- and community-based care services instead of services in a nursing home through the Choices for Care waiver and a plan with details on the recommended use of the appropriation. The plan shall include … the method for determining savings …"

The DAIL deputy commissioner told us that they have neither found any documents to indicate that DAIL has sent a definition of savings to the legislature nor adopted a definition internally.

This issue has been a source of disagreement between DAIL and various advocacy groups and providers. For example, among the opinions expressed

[24] Act 56 (2005) had identical language.

in an October 2009 public hearing related to the extension of the CFC program was a concern and recommendation related to clarifying how savings are defined as well as their reinvestment. DAIL has previously indicated that calculating savings by individual settings or services is not applicable because CFC is managed as a single budget line item rather than as separate line items for nursing facilities and HCBS, as it was prior to the CFC waiver.

There are various alternatives that could be used to define the savings associated with CFC. For example, savings could be defined as (1) how much the state was under the budget neutrality figure in the waiver agreement, (2) the amount of CFC appropriations that are not expended in any given year, or (3) the amount of CFC expenditures that are spent on all participants for HCBS versus how much would have been spent if the highest and high need groups participants were served in nursing facilities. This latter indicator would track cost avoidance and could be adjusted for the proportion of long-term care participants in HCBS versus nursing facilities prior to CFC implementation.

UMMS and/or DAIL have reported data related to the first two options. However, actual results related to the third option have not been reported. This option would take into account how much is being spent on long-term care for both the Medicaid-eligible and expansion (moderate need) populations and compare it to how much could have been spent under standard Medicaid rules (e.g., no expansion population and limited HCBS availability).

Quality of Care

CFC serves a vulnerable population. This makes the quality of care that they receive especially important because their physical or cognitive conditions (1) subject them to a higher risk of health problems and (2) may make it difficult for them to relay to others that their care is deficient.

The UMMS evaluation plan and evaluation reports include some quality of care performance indicators. In particular, the plan and reports include questions asked of selected HCBS participants in surveys, which include, for example, questions related to the quality of the services and whether they meet their needs. However, these indicators are limited in that (1) the survey does not address about 60 percent of the CFC participants (i.e., those residing in nursing facilities and ERCs) and (2) although an important indicator of participant satisfaction, self-reporting of satisfaction levels can be

exaggerated. Additional indicators in the quality of care area that rely on hard data could provide a more complete picture of the quality of care being received by CFC participants.

Organizational Indicators

Nursing facility, enhanced residential care facilities, and HCBS organizations undergo DAIL quality reviews. These reviews result in reports with findings and/or recommendations. Reporting summary-level data on the results of these reviews could provide an indicator of whether providers are providing services in accordance with established standards of care. For example, indicators related to the percentage of a type of provider that have been found to have a deficiency or a type of deficiency could provide information about the level of care being provided as a whole.

It should be noted that it may not be possible to compare the results of the quality reviews among different provider types. UMMS found that the different reviews performed by DAIL use different standards and procedures.[25]

Participant-Related Indicators

There are many indicators that can be used to measure whether individuals have received high quality care. Examples of those that have been used or recommended by others include:

- Rate of pressure sores. Pressure sores are areas of damaged skin that result from staying in one place too long and can have serious medical consequences. A lower rate of pressure sores can indicate higher performing providers.

- Rate of hospital admissions or emergency care.[26] Effective care can reduce the likelihood of hospitalizations or the need for emergency care.

In addition, as Vermont rebalances its long-term care program and enrolls more individuals in HCBS rather than nursing facilities, performance indicators such as these can also be used for comparison purposes and to track whether there are differences in the quality of care indicators in each

[25] *Vermont Choices for Care Policy Brief: Quality Oversight* (UMMS, April 2009).

[26] The CFC evaluation plan includes a more limited indicator, decreased rates of hospitalization of ambulatory care-sensitive conditions. Actual results have not been reported for this indicator.

Appendix V

Potential Areas of Performance Indicators

group. Such comparisons could provide additional insight into the extent to which the use of HCBS benefits long-term care participants.

Appendix VI

Comments from the Commissioner of DAIL

VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Commissioner's Office
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April 2, 2012

Thomas Salmon, CPA, CFE
State Auditor
Office of the State Auditor
132 State Street
Montpelier, VT 05633

Dear Mr. Salmon,

Thank you for sending the draft of your audit of the Choices for Care program Demonstration Waiver program.

DAIL welcomed the opportunity to have your office address the question of whether and how we could more effectively use performance measurement to evaluate the success of the Choices for Care program pursuant to Act 63 (2011). The audit was particularly timely because our external evaluators at the University of Massachusetts Medical School have just submitted their final evaluation of the program for Years 1-6. The two reports taken together give DAIL and our Advisory Board an exceptional opportunity to improve our performance measurement system for the next five years.

We appreciated the professionalism and thoroughness displayed by Ms. Lambert during her audit.

I have reviewed the draft report with my senior staff. As you requested, we have provided comments on the findings, conclusions and recommendations contained in the report. You'll see we agree with some of the findings, conclusions and recommendations and challenge others. We have also outlined the actions we intend to take and a timeline for completion.

Thank you again for this thoughtful look at the Choices for Care program.

Sincerely,

Susan Wehry, M.D.
Commissioner

Appendix VI

Comments from the Commissioner of DAIL

DAIL Comments Table (3/29/12)

#	Document Location	DAIL Comment
	Findings	
1	Page 8, Table, Evaluation and Monitoring Requirement: ***Determine the effect of CFC and its policies on participant satisfaction.***	Relevant data concerning persons who live in nursing homes may be available from the VT Healthcare Association or from Quality of Life Surveys through the Division of Licensing and Protection, although this may require modifying surveys, adding new provider requirements, and/or new data use agreements.
2	Page 8, Table, Evaluations and Monitoring Requirement: ***Determine the effect of CFC and its policies on the array and amounts of services available in the community.***	DAIL does not agree with the representation that CFC was intended to increase the array of services available to people who are *not* eligible for or enrolled in CFC. Over the life of the CFC waiver, the array and amount of services provided to CFC participants has increased substantially. During this time, the number of available beds in nursing homes has decreased; the number of people served through ERC in residential care and assisted living has increased; the number of people served in the MNG has increased substantially. We do believe there has been an increase and that there is a correlation between the increase and CFC policies.
3	Page 15, Title: ***Evaluation of CFC Could Benefit From Use of Targets***	DAIL agrees that the evaluation plan would now benefit from the establishment of more discrete targets for a smaller number of indicators.
	Conclusions	
4	Conclusions, Page 17 ***With annual expenditures approaching (and expected to soon exceed) $200 million, the Choices for Care program uses substantial federal and state resources. In addition, this program provides critical services to a vulnerable population. Accordingly, it is important that an effective performance measurement framework be established to assess the extent to which the program is successful—from both a fiscal and participant perspective.***	DAIL agrees with the first part of the conclusion statement *"it is important that an effective performance measurement framework be established to assess the extent to which the program is successful.* However, we think the framework proposed in the remainder of the sentence *—from both a fiscal and participant perspective."* is insufficient and does not reflect either the current CFC evaluation framework, legislative direction for health reform or other approaches to evaluating long- term care e.g. AARP and scan foundation. DAIL suggests this be revised to describe outcomes and performance - e.g. individual outcomes, financial management and

Appendix VI

Comments from the Commissioner of DAIL

	DAIL has adopted a performance framework that includes outcomes, evaluation questions, and performance indicators that could potentially effectively measure the CFC program from both of these perspectives. However, since actual results were not reported for almost half of the indicators and targets were not established, this potential has not been fulfilled. In particular, feedback has not been sought on more than half of the CFC participants and major evaluation areas have not been assessed. Accordingly, DAIL lacks the information needed to fully assess the extent to which the CFC program has been successful as a whole and may not identify performance gaps that require attention.	performance, systemic outcomes and performance. DAIL agrees that not all of the originally identified indicators have been tracked. DAIL does not agree with the conclusion that DAIL therefore *"lacks the information needed to fully assess the extent to which the CFC program has been successful"*. DAIL believes that CFC has succeeded in what many would consider to be among the most important measures/indicators: more people served overall; more people served in the community; fewer people served in nursing homes; high rates of satisfaction in the community; more service options available and used in the community including PACE, Flexible Choices and paying spouses. DAIL believes this conclusion should be revised to reflect evidence/ facts regarding actual success. In short, DAIL does have quite good evidence of success and agrees we could and should have even better evidence - through a combination of (a) reducing the plethora of measures that made sense back when we envisioned more resources; (b) setting performance targets for those measures that remain; and (c) consistently measuring progress for those that remain.
	Recommendations	
5	Recommendation #1, Page 17: ***Identify a set of indicators that may be the best predictors of individuals at risk for institutional placement, as required by the CFC waiver's Special Terms and Conditions of Approval, or obtain written agreement from CMS to eliminate this requirement from the terms and conditions.***	DAIL agrees with this recommendation. DAIL will consult with UMMS and the DAIL Advisory Board to determine if this measure is still viable and valuable. Depending on the outcome of this determination, DAIL will either seek a written agreement from CMS to remove the requirement from the Special Terms and Conditions or work with UMMS to create a plan to identify a set of indicators by the SFY2013 evaluation report.
6	Recommendation #2, Page 17: ***Identify a set of indicators to determine the effect of CFC and its policies on the array and amounts of services available in the community, as required by the CFC waiver's Special Terms and Conditions of Approval, or obtain***	DAIL agrees with this recommendation and plans to work with UMMS to revise the evaluation plan and measures in the SFY2013 evaluation report.

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Comments from the Commissioner of DAIL

	written agreement from CMS to eliminate this requirement from the terms and conditions.	
7	Recommendation #3, Page 18: ***Identify a set of indicators to assess the effect of CFC on the level of knowledge about long-term care resources in the general public, as required by the CFC waiver's Special Terms and Conditions of Approval, or obtain written agreement from CMS to eliminate this requirement from the terms and conditions.***	DAIL agrees with this recommendation. No later than June 30, 2012 DAIL will consult with UMMS and the DAIL Advisory Board to determine if this measure is still viable and valuable. Depending on the outcome of this determination, DAIL will either seek a written agreement from CMS to remove the requirement from the Special Terms and Conditions or work with UMMS to create a plan to identify a set of indicators in SFY2013 evaluation report.
8	Recommendation #4, Page 18: ***Establish a mechanism to include feedback about CFC participants that reside in nursing facilities and ERCs as part of the evaluation of, at a minimum, the information dissemination, access, experience with care, and quality of life outcomes.***	DAIL agrees with this recommendation. DAIL will work with UMMS to create a plan to include data in the revised evaluation plan by the SFY2013 evaluation report. Relevant data may be available from the VT Healthcare Association or from Quality of Life Surveys through the Division of Licensing and Protection, although this may require modifying surveys, adding new provider requirements, and/or new data use agreements.
9	Recommendation #5, Page 18: ***Ensure that actual results are tracked and reported for all performance indicators in the current CFC evaluation plan or revised CFC evaluation plan should DAIL decide to revisit the plan.***	DAIL agrees with this recommendation and plans to work with UMMS to revise the evaluation plan and measures in the SFY2013 evaluation report.
10	Recommendation #6, Page 18: ***Develop targets against which actual results are compared for the performance indicators in the current CFC evaluation plan or revised CFC evaluation plan should DAIL decide to revisit the plan.***	DAIL agrees with this recommendation and plans to work with UMMS to revise the evaluation plan and measures in the SFY2013 evaluation report.

As a final thought, DAIL would like to suggest omitting the word "but" from the title on both the cover page and page 2 title and inserting a semicolon in its stead. We think you'll agree it captures the findings more accurately and sets a more neutral tone.