Legislative Program Review and Investigations Committee
Connecticut General Assembly

# Factors Influencing Receipt of Long-Term Care Services and Supports in Home and Community Settings

## Staff Findings and Recommendations Report

December 7, 2016

**CONNECTICUT GENERAL ASSEMBLY**
**LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

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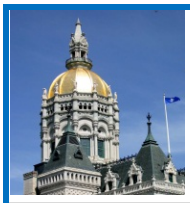

# PRI Staff Findings and Recommendations Highlights

December 2016

## Factors Influencing Receipt of Long-Term Care Services and Supports in Home and Community Settings

## Background

For the last several years, Connecticut state governments, with financial and policy encouragement from the federal government, has undertaken several initiatives that have helped increase the proportion of Connecticut's long-term care services and supports (LTSS) that are delivered in home and community settings rather than in nursing homes and other institutions.

It is generally accepted that it is preferable to increase the percent of people receiving LTSS in the community because: 1) people prefer living in their own homes in a community setting rather than in a nursing home or other institutional setting, and 2) it can be less expensive than delivering services in an institution.

There are two major programs administered by the Department of Social Services (DSS) that provide support for community-based care for frail older adults and people with disabilities. The Connecticut Home Care Program (CHCP) is the primary vehicle used by the state to provide home and community-based care to prevent institutionalization. Money Follows the Person Rebalancing Demonstration (MFP) supports Connecticut's efforts to "rebalance" the long-term support system, by providing transition services and supports to enable institutional residents to return to a home and community based setting. There are also prevention measures that may be taken to reduce the need for LTSS in nursing homes or other institutional settings such as respite for caregivers, fall prevention programs, and congregate housing support services.

PRI staff analyzed information contained in MFP and CHCP databases. Staff also obtained through interviews with state agency personnel, provider groups, and other interested parties. PRI staff also toured nursing home, assisted living, and congregate housing facilities.

## Main Staff Findings

- While an increasing percent live in nursing homes as they age, even at 95+ years of age, two-thirds of CT residents still live in the community.
- Although many believe LTSS prevention and diversion programs, such as fall prevention, telemonitoring, and chronic disease self-management, are helpful, outcome data is scarce.
- Some home and community based Medicaid waivers are more costly than nursing home care; living in the community may sometimes be more a personal choice and philosophy rather than save CT money.
- Compared with 2009/2010, nursing home residents in 2014 have become older and sicker, having more health diagnosed illnesses.
- Regarding MFP:
    - DSS made significant improvements in 7 years in both the # of transitions and time to transition for MFP participants.
    - Despite some concerns from the field, transition outcomes for MFP participants with risk agreements are similar to other transitioners.
    - Risk factors such as cardiac/pulmonary and endocrine diagnoses, and also shorter length of time in preparing for transition, were more prevalent for MFP participants who died within 365 days of transition.
- The LTSS rebalancing ratio of home/community based care to nursing home/institutional care needs to be clarified, and costs better understood. Also,
    - If recalculated to include state-funded LTSS programs and MFP transitioners, then the rebalancing ratio becomes 63.1 percent community to 36.9 percent institutional care.

## PRI Staff Recommendations

**Improvements to LTSS data collection.** Clarify how MFP referrals, transitions, and challenges are captured. Report Nursing Home Registry information in a more useful manner, and require outcome data for fall prevention programs.

**Increased efficiencies to MFP program.** Establish maximum time for certain cases, clarify services available for non-demonstration participants, disseminate favorable outcome on MFP risk assessment participants, provide training on ADL/IADL assessment, ensure planning information is shared, and adequate planning occurs for those with particular risks.

**Calculation of rebalancing ratio.** Develop rebalance ratio for state use only, incorporating home health services, state-funded CHCPE participants, and MFP transitioners. Report LTSS costs in greater detail.

**Other improvements**. Expand the CHCPE care transition role currently provided in some hospitals, and monitor Medicaid waiver waitlists.

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**Acronyms Used in the Transition from Nursing Homes Area**

| Acronym | Meaning |
|---|---|
| ABI | Acquired Brain Injury Waiver |
| ACA | Affordable Care Act |
| ACL | Administration for Community Living |
| ACU | Alternate Care Unit (of DSS) |
| ADL | Activities of Daily Living |
| ASLA | Assisted Living Services Agency |
| BIP | Balancing Incentive Payments Program (performance bonus from feds) |
| CFC | Community First Choice |
| CHCPE | Connecticut Home Care Program for Elders |
| CHCPE-AL | CT Home Care Program for Elders, Assisted Living |
| CHCPE-PCA-AB | CT Home Care Program for Elders, Personal Care Assistance Agency-Based |
| CMS | Centers for Medicaid and Medicare Services |
| CoA | Commission on Aging |
| CT21 | Connecticut Institute for the 21st Century |
| DECD | Department of Economic and Community Development |
| DOH | Department of Housing |
| DPH | Department of Public Health |
| DSS | Department of Social Services |
| HCBS | Home and Community-Based Services |
| IADL | Instrumental Activities of Daily Living |
| ICF/MRs | Intermediate Care Facilities for People with Mental Retardation (ICF/MRs) |
| IDCM | Intensive Discharge Care Management (IDCM) |
| LTSS | Long-term services and supports |
| MAPOC | Medical Assistance Program Oversight Council |
| MFP | Money Follows the Person Rebalancing Demonstration Grant |
| MHSP | Mental Health State Plan |
| MME | Medicare and Medicaid Eligibles |
| NF | Nursing Facility |
| NFLOC | Nursing Facility Level of Care |
| PCA | Personal Care Attendant |
| NWD | No Wrong Door |
| PCMH | Person-Centered Medical Home initiative |
| PDSP | Physical Disability State Plan |
| PERS | Personal Emergency Response Systems |
| PHR | Personal Health Records |
| OPM | Office of Policy and Management |
| SDA | State Department on Aging |
| SNF | Skilled Nursing Facility |
| SPA | State Plan Amendment |
| TEFT | Testing Experience and Functional Tools grant |

**Factors Influencing Receipt of Long-Term Services and Supports in Home and Community Settings**
**Summary of Recommendations**

## Chapter I: Overview of Long-Term Services and Supports and Rebalancing Ratio

1. **The Office of Policy and Management, in conjunction with the Department of Social Services, shall calculate the balance ratio for state reporting purposes (not for federal) annually and include all individuals receiving Connecticut Home Care Program services under state-funded long-term services and supports programs. The calculation shall also include an annual count of those individuals who have transitioned out of institutions into the community under Money Follows the Person prior to being moved onto one of the state's Medicaid waivers or Medicaid state plan options**.

## Chapter II: Connecticut Home Care Program

2. **The Department of Social Services and the Department of Public Health should develop a process to inform each other when certain complaints are verified by either agency and involve employees of home health agencies.**

## Chapter III: Money Follows the Person Demonstration Grant

3. **The Department of Social Services should establish a process to ensure information on transition plans and plans of care is shared among all Money Follows the Person Team members roles are split among multiple organizations.**
4. **The Department of Social Services should distinguish between individuals who signed Money Follows the Person (MFP) consent forms and individuals who did not sign MFP consent forms when reporting such data to the public since it overstates the number of people who were informed about MFP and decided to move forward with an informed consent document.**
5. **The Department of Social Services should monitor and report separately on an unduplicated count of the number of people who transitioned to the community under MFP and the number of <u>referrals</u> that result in transitions to the community.**
6. **The Department of Social Services should determine if all the referrals from the federal Long-Term Care Minimum Data Set Section Q are being captured, and if not, provide training on how to more accurately code source of referral to MFP.**

   **Further, concerns have been raised about whether the question is always asked of nursing home residents as required by federal law. As part of its role of providing nursing home oversight, the Department of Public Health should monitor whether Section Q is being asked of nursing home residents.**

7. **The Department of Social Services should clarify with access agencies the supports and services available to non-demonstration participants.**

8. **The Department of Social Services should establish a maximum length of time that a case with a status of "Transition in Process" should remain open.**

9. **The Department of Social Services should either revisit data entry instructions regarding challenges to transition, or have the evaluator UConn verify that the "no challenges" status still applies**.

10. **The Department of Social Services should review guidelines for completing activities of daily living and instrumental activities of daily living assessments and convey any changes to the access agencies for retraining of their staff who perform these assessments.**

11. **The Department of Social Services should examine whether more planning, preparation time, or other steps should be taken to reduce the post-transition outcome of death for individuals transitioning with the risk factors of cardiac/pulmonary and endocrine/diabetes diagnoses.**

12. **The Department of Social Services should disseminate to access agencies and nursing home personnel the study finding of similar transition outcomes for Money Follows the Person participants with and without risk agreements. This information will address concerns about transitioning such individuals into the community and encourage the promotion of risk agreements when warranted.**

**Chapter IV: Selected Other Medicaid State Plan Long-Term Services and Supports**

13. **The Department of Social Services and the Office of Policy and Management should reach a consensus on the percent of home health service expenditures that should be attributed to Medicaid state plan, Medicaid waiver, and state-funded recipients.**

14. **The Nursing Home Registry should capture information on admissions, readmissions, and discharges, as well as a summary of the number of activities of daily living limitations by resident. In addition, the Nursing Home Registry should report on individuals separately, counting those are considered short-term and are receiving rehabilitation versus those in the long-term care portion of a nursing home.**

15. **The Department of Social Services should conduct an analysis of the distribution of individuals by costs, grouped into cost ranges, for each Medicaid waiver program. A summary of the department's findings should be provided to the legislative committees of cognizance, including the Joint Committee on Appropriations, subcommittee on Human Services.**

## Chapter V: Program to Prevent and Divert Institutionalization

16. **The Department of Social Services should continue to support the care transition role under the Connecticut Home Care Program. The initiative should be phased in to include other Medicaid waiver recipients (Personal Care Assistant, Acquired Brain Injury) and recipients under the Money Follows the Person Demonstration Grant who are hospitalized based on a schedule determined by the Department of Social Services. The responsibilities and role of the Access Agencies should specify criteria for measuring the effectiveness of the intervention in diverting individuals from nursing home admission and should track the increase in services needed to divert such admission.**

    **The Department of Social Services, along with the Access Agencies and hospitals interested in participating in the program, should form a working group to develop a standardized memorandum of understanding that would allow the Access Agencies to enter into data and client record sharing agreements with the hospitals and health networks for the purposes of:**

    - **identifying participants of waivers at the point of admission;**
    - **accessing the waiver recipients electronic health records;**
    - **reviewing and documenting care transition activities;**
    - **accessing the discharge summary to better reinforce discharge plans; and**
    - **accessing home care agency skilled nursing records, nursing home records and physician records if in an Accountable Care Organization.**

    **The Department shall develop and adopt a shared risk tool for hospitals and the Access Agency to use for Medicaid clients to identify those at high risk for readmission/nursing home placement. By targeting Medicaid recipients, hospitalized individuals could be screened for transition services promptly when hospitalized as a nursing home diversion strategy.**

17. **The collection and reporting on outcome data should be a requirement for recipients of funds from the Connecticut Collaboration for Fall Prevention-Statewide Effort (CCFP).**

# Introduction

## Factors Influencing Receipt of Long-Term Care Services and Supports in Home and Community Settings

"Long-term services and supports (LTSS) provide assistance with activities of daily living[1] and instrumental activities of daily living[2] (such as preparing meals, managing medication, and housekeeping). Long-term services and supports are available both in community settings and institutions and include, but are not limited to, nursing facilities care; adult daycare home health aide services, personal care services, transportation, and supported employment as well as assistance provided by a family caregiver."[3]

For the last several years, Connecticut state government, with financial and policy encouragement from the federal government, has undertaken several initiatives that have helped in rebalancing Connecticut's LTSS system away from institutional care and instead, providing care in the community. As part of the efforts to support the Connecticut Long-Term Care Planning Committee efforts to implement a LTSS plan, the Connecticut Office of Policy and Management (OPM) calculates progress toward achieving the state's goal of serving 75 percent of individuals receiving LTSS in the community and 25 percent receiving LTSS in institutions by 2025. This is called a balance ratio.

It is generally accepted that there are two reasons to increase the percent of people receiving LTSS in the community:

1. People prefer living in their own homes in a community setting rather than in a nursing home or other institutional setting.

2. It can be less expensive than delivering services in an institution. However, as discussed below some of the Medicaid waivers existing in Connecticut allow for plans of care for individuals (i.e., services provided in the community) to exceed 100 percent of institutional care.

According to the January 2016 Connecticut Long-Term Care Planning Committee report to the General Assembly for SFY 15, the percent of Medicaid recipients receiving LTSS in the community was 59.6 percent, and the percent of Medicaid recipients receiving LTSS in an institution was 40.4 percent.

[1] Activities of Daily Living (ADS) include routine activities that people can do without needing assistance in eating, bathing, dressing, toileting, transferring and continence."

[2] Instrumental activities of daily living (IADLs) are not necessary for fundamental functioning, but they let an individual live independently in a community and can include: housework; preparing meals; taking medications as prescribed; managing money; shopping for groceries; use of telephone; and use of transportation within their community.

[3] *Medicaid Long Term Services and Supports: A Primer*, Kaiser Family Foundation (May 2015)

There are two major programs administered by the Department of Social Services that provide support for community-based care for frail older adults and people with disabilities that were a focus of this study:

1. The Connecticut Home Care Program (CHCP) is the primary vehicle used by the state to provide home and community-based care to prevent institutionalization (or reinstitutionalization) in a nursing home; and

2. Money Follows the Person Rebalancing Demonstration (MFP), which supports Connecticut's efforts to "rebalance" the long-term support system, to increase the percentage of participants with LTSS living in the community, compared to an institution.

Additionally, there are prevention or diversion measures that may be taken to reduce the need for LTSS in nursing homes or other institutional settings. PRI staff examined efforts in the areas of:

- respite for caregivers:
- care management/transition in hospital settings;
- congregate housing services program;
- chronic disease self-management;
- telemonitoring;
- caregiver education; and
- fall prevention.

**Study Scope and Methodology**

In April 2016, the PRI committee authorized this study of factors influencing receipt of long-term care services and supports in home and community settings (Appendix A). The purpose of the study was to examine what differentiates Connecticut residents who receive LTSS in the community versus nursing homes, and identify ways those findings may be used to increase efficiency and potentially reduce costs.

Over the course of the study PRI staff used the following methods to gather information related to LTSS:

**Interviews with state agency personnel, provider groups, and other interested parties.** PRI staff interviewed numerous Department of Social Services personnel as well as staff at the Department of Public Health, Office of Policy and Management, and State Department on Aging. PRI staff also interviewed the state Long Term Care Ombudswoman, nursing home discharge planners, visiting nurse associations, and the director of the Yale School of Medicine Fall Prevention Program. Also interviewed was AARP, National Multiple Sclerosis Society Connecticut Chapter, Connecticut Association of Health Care Facilities, and Leading Age, a primarily nonprofit nursing home provider agency.

Lastly, PRI staff interviewed directors and other personnel at all five area agencies on aging: North Central Agency Area on Aging, Southwestern CT Agency on Aging & Independent

Living, Western CT Area Agency on Aging, Agency on Aging of South Central CT, and Eastern Senior Resources Agency on Aging. Additionally, PRI staff visited and interviewed the director at Independence Northwest, a center for independent living, and Connecticut Community Care, Inc., an access agency.

**Visits to nursing homes and associated agencies.** PRI staff toured Torringford West, a congregate housing services program in Torrington, Jerome House Nursing Home in New Britain, Arbor Rose Assisted Living Facility in New Britain, and Trinity Hill Care Center in Hartford. PRI staff also accompanied a visiting nurse on a home health care visit in Hartford.

**Analysis of MFP data provided by UConn.** PRI staff worked closely with staff from the UConn Health Center on Aging, the evaluation contractor for the DSS MFP program. UConn provided staff with data for all 7,709 referrals to the MFP program from 12/4/2008 through 6/30/2016 that had a signed informed consent form. Data was downloaded from the MFP web-based database and contained extensive information on demographic characteristics, living arrangements, institutionalizations, disabilities, activities of daily living (ADLs) and instrumental activities of daily living (IADLs), challenges to transition, quality of life surveys administered periodically to MFP participants, and transition outcomes.

**Analysis of CHCPE data provided by ASCEND.** The Connecticut Department of Social Services contracts with the company ASCEND to maintain their web-based system for the Connecticut Home Care Program for Elders (CHCPE). PRI staff chose to analyze all 4,484 cases that had been opened in calendar year 2012 and were assigned to a CHCPE waiver category. In addition to demographic characteristics, ADLs and IADLs, critical incidents, and reason for closure were analyzed.

## Report Organization

This report is organized into five chapters. Chapter 1 gives an overview of the programs and services available in Connecticut that support community living. It also discusses the balance ratio – the percent of individuals receiving long-term services and supports in the community versus in institutional settings--and examines related expenditures. Chapter 2 describes the Connecticut Home Care Program. Chapter 3 provides an analysis of the Money Follows the Person (MFP) Demonstration Grant that assists people in transitioning out of nursing homes or other institutions and back into the community. Selected other LTSS programs are summarized in Chapter 4. Chapter 5 describes programs to prevent and divert institutionalization.

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# Chapter 1

## Overview of Long-Term Services and Supports and the Rebalancing Ratio

"Long-term services and supports (LTSS) provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Long-term services and supports are available both in institutional and community settings and include, but are not limited to, nursing facilities care; adult daycare home health aide services, personal care services, transportation, and supported employment as well as assistance provided by a family caregiver."[1]

Beginning in the mid-1980s, there was recognition that it was personally preferable and more cost-effective to provide LTSS in the community rather than in institutional settings. Since that time, the federal government has changed many of the Medicaid rules to encourage rebalancing efforts away from institutional settings to home and community-based services, including offering several financial incentives.

This chapter provides an overview of LTSS programs. The study focused on two of the community programs--Connecticut Home Care Program for Elders (CHCPE) and Money Follows the Person Demonstration Grant (MFP)--and more details are contained in Chapters 2 and 3, respectively. A profile of nursing homes, the primary institutional setting for LTSS, is provided in Chapter 4.

**Principles of community-based care.** Community-based LTSS have several guiding principles required by the Centers for Medicare and Medicaid Services (CMS) that are aimed at achieving a system that is:

- **Person-driven:** The system affords older people, people with disabilities and/or chronic illness the opportunity to decide where and with whom they live, to have control over the services they receive and who provides the services, to work and earn money, and to include friends and supports to help them participate in community life.
- **Inclusive:** The system encourages and supports people to live where they want to live, with access to a full array of quality services and supports in the community.
- **Effective and Accountable:** The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners and includes personal accountability and planning for long-term care needs, including greater use and awareness of private sources of funding.

[1] Institutional settings include nursing homes, chronic disease hospitals and intermediate care facilities for individuals with intellectual disabilities.

- **Sustainable and Efficient:** The system achieves economy and efficiency by coordinating and managing a package of paid services that are appropriate for the beneficiary and paid for by the appropriate party.
- **Coordinated and Transparent:** The system coordinates services from various funding streams to provide a coordinated, seamless package of supports, and makes effective use of health information technology to provide transparent information to consumers, providers and payers.
- **Culturally Competent:** The system provides accessible information and services that takes into account people's cultural and linguistic needs.

**Home and Community Based Long Term Services and Supports**

The Department of Social Services has received numerous federal grants in the past several years to assist in rebalancing the LTSS system towards community, rather than institutional, care. These funds, along with state funds, are used by DSS to support people in the community. There is a mix of private and public providers who are responsible for screening individuals for program eligibility; conducting assessments of individuals to determine their level of need; and then assisting in identifying service providers.

**Medicaid waiver LTSS programs.** Connecticut offers a variety of services to help eligible individuals who need support to continue to live at home or to assist individuals who live in institutional settings to return to community living. Many of the programs operate under a Medicaid 'waiver,' meaning that Connecticut has received federal approval to waive certain Medicaid requirements to meet the service needs of older adults and adults and children with disabilities in the community.

Table 1-1 shows the 11 Medicaid waivers in Connecticut and the agency responsible for administering it. Federal law historically has had an institutional bias, and only through home- and community-based services Medicaid waivers have states been able to serve frail elders or younger individuals with disabilities in the community and still receive federal matching Medicaid funds. These waivers are targeted to different populations, and have different eligibility requirements. The services provided can vary and the financial caps are placed on the cost of services that are delivered in the community with the intent, under most waivers that the cost is equal to or less than the cost of institutional care. In addition, many of the Medicaid waivers limit the number of people that can be served and therefore have waiting lists.

| Table 1-1. Medicaid Waivers in Connecticut to Promote Long Term Services and Supports | |
|---|---|
| ***Name of Waiver*** | ***Description of Services*** |
| ***Department of Social Services*** | |
| **Connecticut Home Care Program (five Categories, including three state-funded only)** | Serves elders (65 years of age and older) who are either at risk of institutionalization or meet nursing home level of care. Clients must meet functional and financial eligibility criteria. Services include homemaker, companion, personal emergency response system, meals on wheels, adult day care, chore, mental health counseling, assisted living, personal care attendant, assistive technology, adult family living, care management, minor home modifications. |
| **Personal Care Attendant (PCA) Waiver** | Provides personal care assistance services included in a care plan to maintain adults with chronic, severe, and permanent disabilities in the community. Without these services, the adult would otherwise require institutionalization. The care plans are developed with the consumer by an Access Agency care manager. Adults must be age 18-64 to apply, must have significant need for hands on assistance with at least two activities of daily living (eating, bathing, dressing, transferring, toileting), must lack family and community supports to meet the need, and must meet all technical, procedural and financial requirements of the Medicaid program. Medicaid for Employees with Disabilities is an option. Eligible adults must be able to direct their own care and supervise private household employees, or have a Conservator to do so. An adult deemed eligible for the PCA Waiver is eligible for all Medicaid-covered services. Waiting list applies. |
| **Katie Beckett Waiver -** | Serves children and young adults with severe disabilities under age 22. Services include case management and Medicaid coverage aimed at keeping the child or young adult in the community instead of an institutionalized setting. The Home and Community-Based Services that allow the enrollee to remain in the community are provided under the Medicaid state plan. A maximum of 300 slots is funded under legislation. Parents' income and assets are not factored into the initial eligibility. This offers families of all income levels the opportunity to access services they otherwise may not be able to afford. Waiting list applies. |
| **Acquired Brain Injury (ABI) Waivers** | There are two ABI Waiver programs, known as ABI Waiver I and ABI Waiver II. Cost caps on community care plans are different under each waiver. Both employ the principles of person-centered planning to provide a range of non-medical, home and community-based services, to help maintain adults who have an acquired brain injury (not a developmental or degenerative disorder) in the community. Without these services, the adult would otherwise require placement in an institutional setting. Adults must be age 18-64 to apply, must be able to participate in the development of a service plan in partnership with a DSS social worker, or have a Conservator to do so, and must meet all technical, procedural, and financial requirements of the Medicaid program. Medicaid for Employees with Disabilities is an option. An adult deemed eligible for the ABI Waiver is eligible for all Medicaid-covered services. A waiting list applies |

| Table 1-1. Medicaid Waivers in Connecticut to Promote Long Term Services and Supports, Cont'd | |
|---|---|
| ***Name of Waiver*** | ***Description of Services*** |
| ***Department of Developmental Services*** | |
| **Comprehensive Waiver** | Provides services for participants with intellectual and/or developmental disabilities who have significant physical, behavioral, or medical support needs. Provides adult day health, community companion homes/community living arrangements, group day supports, live-in caregiver, respite, supported employment, independent support broker, adult companion, assisted living, behavioral support, continuous residential supports, environmental modifications, health care coordination, individual goods and services, individualized day supports, individualized home supports, interpreter, nutrition, parenting support, personal emergency response systems, personal support, senior supports, specialized medical equipment and supplies, and transportation and vehicle modifications. |
| **Individual and Family Supports Waiver** | Designed to support individuals who live in their own homes or in their family homes and need less extensive supports than individuals on the Comprehensive Waiver. Provides adult day health, community companion homes (formerly community training homes), group day supports, individual supported employment, live-in companion, prevocational services, respite, independent support broker, behavioral support, companion supports (formerly adult companion), continuous residential supports, environmental modifications, group supported employment (formerly supported employment), health care coordination, individualized day supports, individualized home supports, individually directed goods and services, interpreter, nutrition, parenting support, personal emergency response systems, personal support, senior supports, specialized medical equipment and supplies, and transportation and vehicle modifications. |
| **Employment and Day Supports Waiver** | Targets young adults transitioning from school to work with similar services as the other DDS waivers. Provides adult day health, community-based day support options, respite, supported employment, independent support broker, behavioral support, individual goods and services, individualized day support, interpreter, specialized medical equipment and supplies, and transportation. |
| **Early Childhood Autism Waiver** | Serves three- and four-year-olds with autism. Services provided are an ABA-certified clinician and a life skills coach. |
| **Autism Waiver** | Serves individuals ages three and older with an IQ of greater than 70. Services are provided in the person's own home or family home. Provides community companion homes, live-in companion, respite, assistive technology, clinical behavioral support, community mentor, individual goods and services, interpreter, job coaching, life skills coach, non-medical transportation, personal emergency response systems, social skills group, and a specialized driving assessment for individuals. |
| ***Department of Mental Health and Addiction Services*** | |
| **Department of Mental Health and Addiction Services Waiver (i.e., WISE)** | Serves persons with serious mental illness who otherwise require nursing facility level of care with the goal of keeping the person in the community rather than a nursing home. Waiver services complement and/or supplement services available to participants through the Medicaid State Plan and other federal, state, and local public programs, as well as natural supports that families and communities provide. |
| Source: Department of Social Services | |

**Non-Medicaid waiver LTSS programs.** Besides the services offered under the 11 Medicaid waivers, the Department of Social Services provides other LTSS services including:

- state-only funds under the Connecticut Home Care Program (CHCP) for individuals not eligible for Medicaid;
- a Centers for Medicare and Medicaid Services demonstration grant that is time-limited, called Money Follows the Person, targeted at transitioning individuals out of institutions and back into the community; and
- Non-waiver Medicaid services (i.e., services identified in a CMS-approved Medicaid state plan).

**Capacity of Medicaid and state-funded LTSS programs.** Table 1-2 shows the capacity of all the community programs and/or services available to frail older adults and individuals with disabilities, the average monthly recipients in SFY 15, and whether a wait list exists for the program.

**Table 1-2. Number of Recipients in SFY 2015 by Program and Number of Individuals on Waiting List for Services (if applicable)**

| *Program* | *Average Monthly Recipients in SFY 15* | *# Wait Listed as of Nov. 2016* |
|---|---|---|
| | | |
| **Medicaid State Plan:** | n/a | n/a |
| Home Health Services | n/a | n/a |
| Community First Choice | n/a | n/a |
| Medicaid 1915(i) | n/a | n/a |
| | | |
| **Medicaid Waiver:** | | |
| ABI I | 434 | n/a |
| ABI II | 105 | 41 |
| CHCPE Category 3 | 12,349 | n/a |
| Katie Beckett | 300 | 184 |
| PCA | 1,098 | 1,456 |
| DDS Comprehensive | 5,050 | * |
| IFS | 4,250 | * |
| Employment and Day Supports | 1,350 | * |
| Early Childhood Autism | 50 | * |
| Autism | 122 | * |
| DMHAS WISE | 286 | n/a |
| | | |
| **Medicaid Demonstration Grant:** | | |
| Money Follows the Person | n/a | n/a |
| | | |
| **CHCP State Funded:** | | |
| Category 1 (CHCPE) | 744 | 380 |
| Category 2 (CHCPE) | 2,563 | n/a |
| Category 4 (CHCPD) | 100 | 10 |
| | | |
| TOTAL | 28,801 | 2,030 |

*The Department of Developmental Services does not categorize its wait list for services by Medicaid Waiver Categories. Rather it bases it on the degree of emergency placement needed.
Source: Departments of Social Services and Developmental Services.

## Institutional Long Term Services and Supports

Prior to the delivery of long-term services and supports in home and community based settings, institutions were the dominant provider of LTSS. There are three general types of institutional care: nursing facilities; intermediate care facilities for individuals with intellectual disabilities (ICF/IID); and chronic disease hospitals (e.g., Gaylord Hospital). Table 1-3 shows the monthly average number of Medicaid recipients receiving LTSS in institutions in SFY 2015.

**Table1-3. Monthly Average Number of Medicaid Recipients Receiving LTSS in Institutions (SFY 15)**

| ***Type of Facility*** | ***Monthly Average Served*** |
|---|---|
| Nursing Facilities | 17,273 |
| Hospice | n/a |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) | 378 |
| Chronic Disease Hospitals | 349 |
| **Grand Total** | 18,516 |

Source: Office of Policy and Management and Department of Social Services

## The Balance Ratio

For the last several years, Connecticut state government, with financial and policy encouragement from the federal government, has undertaken several initiatives that have helped in rebalancing Connecticut's LTSS system away from institutional care and instead, providing care in the community. As part of the efforts to support the Connecticut Long-Term Care Planning Committee initiatives to implement its LTSS plan, the Connecticut Office of Policy and Management (OPM) calculates progress toward achieving the state's goal of serving 75 percent of individuals receiving LTSS in the community and 25 percent receiving LTSS in institutions by 2025. This proportion of community to institutional LTSS is referred to as the balance ratio.

The balance ratio is important because it represents a state's progress toward meeting the goal of providing individuals with care in the community rather than in an institutional setting, such as a nursing home. It is generally accepted that there are two reasons to increase the percent of people receiving LTSS in the community:

1. people prefer living in their own homes in a community setting rather than in a nursing home or other institutional setting.

2. It can be less expensive than delivering services in the community. However, as discussed below, some of the Medicaid waivers existing in Connecticut allow for plans of care for individuals (i.e., services provided in the community) to exceed 100 percent of institutional care.

According to the latest Connecticut Long-Term Care Planning Committee report to the General Assembly (January 2016), for SFY 15, of the 45,876 Medicaid recipients receiving LTSS, 59.6 percent (27,360) received these in the community and 40.4 percent (18,516) in an institution. The percent of Medicaid LTSS clients receiving services in the community has increased three percent since 2012, when the balance ratio was 56 percent of the individuals served in a community setting compared to 44 percent served in institutions.

The Money Follows the Person (MFP) Demonstration Grant (described in Chapter 3 has two benchmarks related to the rebalancing goal:

- increase dollars to home and community based services; and
- increase the percentage of long term care participants living in the community compared to an institution.

The balance ratio has two important components. First, the Centers for Medicare and Medicaid (CMS) requires DSS to report on Medicaid expenditures used for LTSS in the community versus an institutional setting. The second component, calculated by the Office of Policy and Management, identifies the number of individuals being served in each type of setting.

**Federal grants received and other incentives to rebalance**. As noted above, DSS has applied for and received several federal grants to help finance rebalancing of the LTSS system by increasing the availability of community supports. Table 1-4 describes each grant received and Table 1-5 shows the award period, the amount received and the total expended through September 30, 1916. It should be noted the Nursing Home Diversification project is part of the Money Follows the Person Demonstration Grant but is shown separately in order to illustrate funds going towards nursing homes that wish to expand their business models to incorporate community-based care.

**Connecticut's balance ratio.** The Centers for Medicare and Medicaid requires DSS to calculate the expenditure side of the balance ratio annually for reporting purposes. It shows the amount of Medicaid expenditures that were paid for community versus institutional care. The Office of Policy and Management also calculates a balance ratio for the purpose of informing Long-Term Care Planning Committee members of achievement towards rebalancing the LTSS system in favor of community care. OPM's methodology uses a state fiscal year as its calculation time and includes a calculation of the total number of individuals who are being served in each setting under a Medicaid program.

To calculate these ratios, DSS limits total expenditures incurred for, and OPM limits the number of individuals counted to, Medicaid recipients only (except individuals transitioning out of institutional care under the Money Follows the Person Demonstration Grant are not included in the count). Thus, only individuals eligible for Medicaid under the state plan or one of 11 Medicaid waivers granted to Connecticut by CMS are counted towards the ratio. This means that individuals who might be receiving long-term care in community or institutional settings are not counted, including those who:

| Table 1-4. Description of Federal Grants and Enhanced Funding Awarded to Connecticut to Promote Rebalancing | |
|---|---|
| ***CMS Grants Received*** | ***Description of Grant*** |
| Balancing Incentive Program | The Balancing Incentive Program provided financial incentives, through enhanced federal Medicaid match to increase access to non-institutional long-term services and supports (LTSS) in keeping with the integration mandate of the Americans with Disabilities Act (ADA), as required by the *Olmstead* decision, and was created by the Affordable Care Act of 2010. Program requirements included: 1) development of "no wrong door" system; 2) pre-screening and comprehensive assessment tool; 3) conflict-free case management so that assessment providers are separate from care delivery; and 4) new supports and services to help individuals remain in the community. |
| Money Follows the Person | In order to enable more Medicaid recipients living in long term care facilities, such as nursing homes, to move back to their communities, DSS applied to participate in the National Money Follows the Person Rebalancing Demonstration. The application was successful and the award was granted in 2007.<br><br>The demonstration is the largest Medicaid systems change initiative ever funded by the federal government. Connecticut's Demonstration has 2 goals: 1) Reduce reliance on institutional care; 2) Increase the efficiency and effectiveness of long term care systems. |
| Nursing Home Diversification (Right Sizing Budget) | This funding is intended to help Connecticut's nursing home industry develop new business models that would diversify services to meet the changing needs of older adults and other citizens with disabilities. The grant is part of the state MFP initiative to expand long-term service options for people who can live safely in the community instead of an institution. |
| Testing Experience and Functional Tools (TEFT) | This grant is to test quality measurement tools and demonstrate use of Personal Health Records and electronic LTSS. TEFT has four components: 1) development of an experience-of-care survey; 2) testing of the National Functional Assessment Standard; 3) development of personal health records; and 4) development of a national electronic long-term services and supports standard. |
| Source: Department of Social Services | |

| Table 1-5. Amount of Federal Grants Awards and Enhanced Medicaid Revenue Received | | | |
|---|---|---|---|
| ***CMS Grants Received*** | ***Grant Award/Period*** | ***Total Amount Awarded*** | ***Total Expended through QE 9/30/16 (Federal Share)*** |
| Balancing Incentive Program* | 1/1/13 – 9/30/15 | $78,070,000 | $77,497,673 |
| Money Follows the Person | 1/1/07-9/30/20 | $234,576,991 | $122,908,359 |
| Nursing Home Diversification (Resizing Budget) | 1/1/07-9/30/20 | $29,444,107 | $4,121,337 |
| Testing Experience and Functional Tools (TEFT) | 5/1/14 – 4/30/18 | $3,182,671 | $603,383 |
| *Not a grant but enhanced federal Medicaid revenue to be used for new or expanded LTSS.<br>Source: Department of Social Services | | | |

- do not qualify for Medicaid and therefore, self-pay for institutional or community services;
- have informal (unpaid) caregivers;
- are receiving long-term care through a fully state-funded program (e.g., the Connecticut Home Care Program Categories 1, 2, and 4 participants);
- transition out of an institution under MFP funds (they are included after MFP, on day 366 in the ratio only when they transfer to a Medicaid waiver program; and
- receive services supported by Older American Act funds, administered by the State Department of Aging, and provided through the Area Agencies on Aging.

Contained in the January 2016 Connecticut Long-Term Care Planning Committee report, entitled *Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut*, are statistics on Medicaid expenditures and the number of individuals who reside in institutional versus community settings. It also has projections on the shift needed to achieve the goal of serving 75 percent of individuals in the community and 25 percent in institutions.

Table 1-6 shows that in SFY 15, 60 percent of Medicaid LTSS recipients were being served in the community. The Long-Term Care Planning Committee estimates, rebalancing the LTSS system to the optimal ratio of 75/25 percent, Connecticut could expect an additional 14,062 recipients receiving community-based care and 4,415 fewer individuals would need to receive institutional care in order to achieve the state's goal by 2025. In addition, the planning committee estimates that Medicaid expenditures would be $657 million less than in SFY 15 because serving individuals in the community, on average is less expensive.

**Table 1-6. SFY 15 and Projected SFY 2025 Ratios and Expenditures (in billions)**

| *Setting* | *Client Ratio in SFY 15* | *Medicaid Expenditure in SFY 15* | *Optimal Client Ratio in SFY 25* | *Projected Medicaid Expenditure with Optimal Ratio* |
|---|---|---|---|---|
| HCBS | 59.6% | $1.3 | 75% | $3.6 |
| Institutional Care | 40.4% | $1.6 | 25% | $2.3 |
| Total | 100% | $2.9 | 100% | $5.9 |

Source: Connecticut Long-Term Care Planning Committee, *Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut*, A report to the General Assembly, January 2016, p. 48.

**The community side of the equation in detail**. OPM calculates the number of recipients of Medicaid-funded LTSS in the community by summing the monthly average number of participants in each of the 11 Medicaid waiver programs. Table 1-7 shows a breakout of the 27,360 individuals receiving services under home and community based waiver programs.

As noted above, OPM excludes the number of recipients served by MFP. According to OPM, MFP participants who are in their second year on MFP and, therefore, have been officially

enrolled into the waiver programs, are included in the Table 1 waiver statistics.

Also, the 3,623 individuals receiving Targeted Case Management/Mental Health (shown in Table 1-7) (that is part of the Medicaid State Plan Mental Health Service), can also receive other services through a Medicaid waiver as long as the service is not case management (because a person cannot receive the same service through both the State Plan and a Waiver). Thus, there may be some clients that are counted twice.

**Table 1-7. Medicaid Waiver Programs and Some State Plan Services for Home and Community Based Services (HCBS).**

| ***Medicaid Waiver and State Plan Programs for Home and Community Based Services (HCBS):*** | ***Monthly Average Served in FY 15*** | ***SFY 15 Total Expenditures (State and Federal)*** |
|---|---|---|
| ***Listed Under DSS Community Options Unit*** | ***(13,709 served across the 4 waivers for DSS clients)*** | ***$527,822,438*** |
| Connecticut Home Care Program for Elders (CHCPE)[1] | 12,303 | $272,616,186 |
| Personal Care Attendant (PCA) (18-64 years old) | 782 | $35,883,175 |
| Katie Beckett (up to age 22) | 240 | $57,780 |
| Acquired Brain Injury (ABI I & II) (18-64 years old) | 384 | $53,018,326 |
| Home Health Services* | | $158,570,263 |
| Hospice | data not available | $2,646,708 |
| ***Listed Under DDS*** | ***(9,661 served across the 5 waivers for DDS clients)*** | ***$750,726,422*** |
| Comprehensive Waiver/DD | 4,976 | $634,933,206 |
| Individual and Family Supports Waiver/DD | 3,934 | $104,673,847 |
| Employment and Day Supports Waiver/DD | 637 | $10,353,046 |
| Autism Spectrum Disorder Waiver/DD | 95 | $766,343 |
| Early Childhood Waiver (Autism)/DD (3-4 yrs old) | 19 | |
| ***Listed Under DMHAS*** | ***(3,990 served across the 2 waivers for DMHAS clients)*** | ***$37,524,158*** |
| Mental Health Waiver (WISE) | 367 | $8,501,658 |
| Targeted Case Management/Mental Health (state plan mental health service) | 3,623 | $29,022,500 |
| ***LTSS Home and Community Care*** | | |
| **Grand Total** | **27,360** | **$1,311,043,038** |

[1] Includes CHCPE Category 3 and 1915(i) state plan portion of CHCP (Category 5), both of which are for 65+ year olds. Excludes CHCPE Categories 1 and 2, which are also for 65+ year olds and fully funded by the state and receive no Medicaid dollars. Also excludes the fully state-funded CHCPD Category 4 (for individuals under age 65 with a degenerative neurological condition) who are ineligible for Medicaid.
*Home health expenditures are based on an estimate of the percentage of Medicaid recipients receiving long-term home health care as opposed to short-term care.
Source: Office of Policy and Management and Department of Social Services

**The institutional side of the equation in detail**. OPM also calculates the number of recipients of Medicaid-funded LTSS in institutions. These numbers are calculated by summing the monthly average number of participants in each of the three types of institutional care:

- nursing facilities;
- intermediate care facilities for individuals with Intellectual Disabilities (ICF/IID); and
- chronic disease hospitals.

Table 1-8 shows the breakout of 18,516 individuals (40.4 percent) receiving Medicaid-funded LTSS in one of three types of institutional settings. It shows:

- Medicaid recipients receiving LTSS in an institution mainly reside in nursing facilities (93 percent);
- there are some individuals with intellectual disabilities who reside in intermediate care facilities (4 percent); and
- there are some individuals who reside in chronic disease hospitals; (2 percent).

**Table1-8. Expenditures for Medicaid Recipients Receiving LTSS in Institutions (SFY 15)**

| *Type of Facility* | *Monthly Average Served* | *Total Expended* |
|---|---|---|
| Nursing Facilities | 17,273 | $1,204,861,069 |
| Hospice | n/a | $33,483,504 |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) | 378 | $254,824,602 |
| Chronic Disease Hospitals | 349 | $84,810,738 |
| **Grand Total** | 18,516 | $1,577,979,913 |
| Source: Office of Policy and Management and Department of Social Services | | |

**Persons excluded from the ratio**. As shown in Table 1-9, in addition to MFP recipients, there were 4,357 individuals in SFY 15 who received long-term care in a fully state-funded community-based program and have been excluded from the balance ratio.

**Table 1-9. Number of Individuals Not Counted in Current Balance Ratio for SFY 15**

| *Program* | *Number of Clients* |
|---|---|
| CHCPE category 1 | 1,101 |
| CHCPE category 2 | 2,457 |
| CHCPD category 4 of CHCP | 100 |
| MFP (days 1-365) | 699 |
| **Total** | 4,357 |
| Source: PRI staff analysis. | |

If state-funded CHCP clients were included in the calculation in SFY 2015, for example, this would have added 3,658 recipients to the balance ratio. Also, an additional 699 MFP recipients could be added to the balance ratio as they are excluded from the counts in Medicaid waiver programs. **Thus, a total of 4,357 individuals could be included in the state's balance ratio.** While PRI staff realizes that CMS does not allow state-funded recipients to be counted for federal reporting, staff believes that these numbers should be included in a separate state report. Connecticut's efforts should be reflected in the balance ratio since it serves people with state dollars and the current calculation underrepresents the state's rebalancing effort.

As shown in Table 1-10, **if these individuals were included, the state's balance ratio would be 63.1 percent of individuals are receiving LTSS in the community versus 36.9 percent in institutional settings, a significant difference.** By including these recipients, a true reflection of the state's progress can be measured so that policymakers are more cognizant of achievement toward the state's goal. **Therefore, PRI staff recommends:**

> **The Office of Policy and Management, in conjunction with the Department of Social Services, shall calculate the balance ratio for state reporting purposes (not for federal) annually and include all individuals receiving Connecticut Home Care Program services under state-funded long term services and supports programs. The calculation shall also include an annual count of those individuals who have transitioned out of institutions into the community under Money Follows the Person prior to being moved onto one of the state's Medicaid waivers or Medicaid state plan options**.

**Table 1-10. Recalculated Balance Ratio Including State-Funded CHCP Recipients and MFP Recipients for SFY 15**

| ***Setting*** | ***Number of Recipients in SFY 15*** | ***Balance Ratio*** |
|---|---|---|
| HCBS | 27,360 + 4,357 = 31,717 | 63.1% |
| Institutional | 18,516 | 36.9% |
| Total | 50,233 | 100% |
| Source: OPM and PRI Staff Analysis | | |

It should be noted, recipients of categories 1 and 5 of CHCPE are considered at risk of hospitalization rather than institutional care and therefore the cost caps on their plans of care are 25 percent of nursing home cost. However, since CMS allows Connecticut to include Medicaid expenditures for individuals that are eligible under Category 5 in its balance ratio, PRI staff believes that OPM should also include state-funded Category 1 individuals in its calculations the next time it reports to the LTC Planning Committee.

OPM may also want to consider adding certain other individuals to the calculation, such as those that receive the Congregate Housing Services Program (CHSP), which has the purpose of preventing unnecessary institutionalization (described in Chapter 5). Since individuals who qualify for the program must have at least 3 ADL limitations, it is possible they would meet nursing level of care in the absence of the program.

# Chapter 2

## Connecticut Home Care Program

One Medicaid Waiver program administered by DSS that was a focus of the PRI study is called the Connecticut Home Care Program (CHCP). It is considered the state's premier program to serve frail elderly and persons under 65 with neurological diseases (CHCPD) in avoiding unnecessary or premature nursing home care by making available a variety of community-based services. It also helps those who have left nursing homes under the Money Follows the Person Demonstration program. The goal of the program is to reduce the need for costly nursing home care by providing home health services and assistance with activities of daily living.

The program is funded from two separate accounts: the Medicaid account, which is matched by federal funds (Category 3 and Category 5 of CHCPE); and the Connecticut Home Care Program account, which is funded solely by the state (Categories 1, 2 and 4). Individuals who are eligible under the Medicaid waiver also qualify for regular Medicaid state plan services. Applicants must have function limitations and meet financial eligibility requirements.

Table 2-1 describes, in detail each of the five categories of eligibility and the level of funding allowed for an individual's plan of care, which differs by category. (Appendix B provides more information on eligibility criteria.) The funding level depends on whether a person is eligible for the Medicaid waiver program; qualifies under the Medicaid state plan option; or does not meet either criteria but is eligible for one of the two state-funded categories. As of November 2016, the program served a total of 16,370 individuals and there were 390 individuals on a Wait List for services.

*Cost limits on plans of care***.** The table also shows an individual's eligibility category determines the maximum cost cap (or budget) for an individual's plan of care (services). The reason for this is so the cost of delivering care in the community, with some exceptions, does not exceed the cost of nursing home care or other institutional setting.

Once a care plan is completed by a care manager assessing the client, DSS must approve the cost of services contained in the plan. Prior to 2016, the state's cost for the client's total plan could not exceed the average weighted state cost of nursing facility care. However, as a result of unionization of personal care assistants in Connecticut, which require additional expenses for overtime pay, the cost caps are now 115 percent of the average weighted cost of nursing facility care. Thus, the new cost limits for Category 3 CHCPE recipients have the highest caps, set at $6,690 per month or $80,280 annually. Cost caps for each category are shown in Table 2-1.

*Copayments under the state-funded categories of CHCP*. The state-funded categories have statutory cost-sharing requirements for all recipients with the current copay set at 9 percent of the cost of services. The department indicated that the copayment collected from program recipients is currently about $300,000 per month. In addition to the copay, participants with income above 200 percent of the federal poverty level must contribute based on their "applied

| Table 2-1. Connecticut Home Care Program (CHCP) | | | | |
|---|---|---|---|---|
| ***Category*** | ***Population Served*** | ***Funding*** | ***Description*** | ***Care Plan Limit Monthly Cost Cap: 2016*** |
| 1 | Elders | State Only | Program for moderately frail elders with **1 or 2 critical needs** and at risk of long-term hospitalization or nursing facility placement, but do not need immediately placement. ***The program stopped accepting new clients as of July 1, 2015 – 380 Individuals on Waiting List as of November 2016*** | *25% of nursing home average Medicaid rate: $1,454* |
| 2 | Elders | State Only | Program for very frail elders with **3 or more critical needs** who require nursing facility care but exceed Medicaid eligibility criteria**.** | *50% of nursing home average Medicaid rate: $2,909* |
| 3 | Elders | Medicaid Waiver | Extensive home care for very frail elders with **3 or more critical needs** who would otherwise be in a nursing home on Medicaid. | *115% of nursing home average Medicaid rate: $6,690* |
| 4 | Under 65 Degenerative | State Only | Pilot program for persons under age 65 with **3 or more critical needs**, have degenerative neurological conditions and are ineligible for Medicaid. ***Program capped at 100 recipients – 10 individuals on Waiting List as of November 2016*** | *50% of nursing home average Medicaid rate:* $,2,909 |
| 5 | Elders | Medicaid State Plan | Program for moderately frail elders that are Medicaid eligible, have **1 or 2 critical needs** and are at risk of long-term hospitalization or nursing facility placement, but do not need immediately placement. | *25% of nursing home average Medicaid rate: $1,454* |
| Source: Department of Social Services | | | | |

income."[1] The amount of the copay has been changed legislatively several times over the years. The copay history is:

- January 2010 - 15 percent (inception of copay)
- July 1, 2010 – 6 percent
- July 1, 2011 – 7 percent
- July 1, 2015 – 9 percent

If a state-funded client fails to pay the copay, his or her services are discontinued because these services are not an entitlement like under Medicaid. Based on interviews with Access Agency staff, there is a belief that these cost-sharing requirements may deter some individuals from entering the program. This, according to some Access Agency staff interviewed, was the reason the copay was reduced from 15 percent to six percent only six months after being introduced in January, 2010.

The Department of Social Services issues an annual report for the Connecticut Home Care Program with information on clients. The last report was issued on December 17, 2015 and contained client and cost information for SFY 2014. In its report, the department indicated:

- the total number of unduplicated recipients was 18,540;
- expenditures across all five program categories totaled $338,080,974
  - Net state expenditures after federal reimbursement was $214,786,762 – based on a 50 percent federal Medicaid match plus state expenditures for the state-funded only categories;
- there were 13,178 recipients eligible under the Medicaid waiver compared to the state funded group which accounted for 4,738 recipients;
- services in the state-funded categories totaled $45,746,275; and
- the average annual cost of CHCPE services per recipient for Medicaid waiver clients was $21,775 versus state-funded per-client cost of $9,655.

The services covered under CHCP are shown in Table 2-2 and show, by category (state-funded is combined), the number of annual recipients, total expenditures and annual cost per service provided. There is a wide variety of services provided to recipients, such as home-health aides, homemaker aides, companions, adult day care, personal assistance, and meals on wheels.

The top five services, in terms of annual cost per recipient, are shown in Table 2-3. It is important to note that individuals may receive multiple services; thus the average cost of care for an individual can be far higher than any single service expenditure shown in the table.

[1] Participants residing in affordable housing the state's assisted living demonstration project and individuals in Category 4 of the program pay only the applied income above 200 percent of the FPL. Applied income is calculated by subtracting an individual's medical expenses from his or her gross income and compares this to 200 percent of the FPL. If the applied income is higher, the client pays the difference.

Table 2-2

**Connecticut Home Care Program for Elders**
**SFY 2014**
**Average Annual Cost per Case Summary**

**Statewide**

| | | Title XIX | | | State Funded | | | 1915i | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MAR COS | Annual Recipients | Annual Expenditures | Cost / Service | Annual Recipients | Annual Expenditures | Cost / Service | Annual Recipients | Annual Expenditures | Cost / Service | Annual Recipients | Annual Expenditures | Cost / Service |
| **Screening Services** | | | | | | | | | | | | | |
| Assessments | 611 | 2,715 | $ 764,704 | $ 281.66 | 4,164 | $ 1,176,086 | $ 282.44 | 113 | $ 29,589 | $ 261.85 | 6,992 | $ 1,970,379 | $ 281.80 |
| Reviews | 612 | 1,151 | $ 133,849 | $ 116.29 | 509 | $ 53,772 | $ 105.64 | 19 | $ 1,947 | $ 102.46 | 1,679 | $ 189,567 | $ 112.90 |
| Health Screens | 613 | 100 | $ 10,586 | $ 105.86 | 116 | $ 14,335 | $ 123.58 | 35 | $ 2,399 | $ 68.55 | 251 | $ 27,321 | $ 108.85 |
| Misc. Adjustments (a) | | | | | | | | | | | | | |
| **Sub-Total** | | | **$ 909,139** | | | **$ 1,244,193** | | | **$ 33,935** | | | **$ 2,187,267** | |
| **Waiver Services** | | | | | | | | | | | | | |
| Case Management | 601 | 13,178 | $ 17,098,020 | $ 1,297.47 | 4,738 | $ 4,993,129 | $ 1,053.85 | 624 | $ 882,133 | $ 1,413.67 | 18,540 | $ 22,973,282 | $ 1,239.12 |
| Adult Day Health | 602,841 | 1,626 | $ 12,927,638 | $ 7,950.58 | 415 | $ 2,414,776 | $ 5,818.74 | 93 | $ 485,286 | $ 5,218.12 | 2,134 | $ 15,827,700 | $ 7,416.92 |
| Chore | 603,842 | 438 | $ 388,588 | $ 887.19 | 103 | $ 65,681 | $ 637.68 | 19 | $ 8,046 | $ 423.49 | 560 | $ 462,315 | $ 825.56 |
| Companion | 604,843 | 6,806 | $ 41,231,589 | $ 6,058.12 | 1,807 | $ 5,703,554 | $ 3,156.37 | 386 | $ 908,919 | $ 2,354.71 | 8,999 | $ 47,844,061 | $ 5,316.60 |
| Elderly Foster Care | 605,84D | 7 | $ 23,499 | $ 3,356.94 | 1 | $ 3,961 | $ 3,961.22 | 0 | $ - | | 8 | $ 27,460 | $ 3,432.47 |
| Meals | 606,844 | 4,779 | $ 8,053,424 | $ 1,685.17 | 1,167 | $ 1,271,614 | $ 1,089.64 | 299 | $ 604,909 | $ 2,023.11 | 6,245 | $ 9,929,947 | $ 1,590.06 |
| Homemaker | 607,845 | 8,833 | $ 36,991,778 | $ 4,187.91 | 3,111 | $ 7,349,952 | $ 2,362.57 | 536 | $ 1,401,724 | $ 2,615.16 | 12,480 | $ 45,743,454 | $ 3,665.34 |
| Mental Health Couns. | 608,846 | 637 | $ 515,580 | $ 809.39 | 83 | $ 43,894 | $ 528.85 | 31 | $ 19,672 | $ 634.59 | 751 | $ 579,147 | $ 771.17 |
| Personal Emerg. Resp. | 609,847 | 8,512 | $ 3,381,233 | $ 397.23 | 2,957 | $ 943,218 | $ 318.98 | 317 | $ 118,437 | $ 373.62 | 11,786 | $ 4,442,888 | $ 376.96 |
| Respite Care | 60A,848 | 23 | $ 75,453 | $ 3,280.56 | 17 | $ 29,537 | $ 1,737.49 | 0 | $ - | | 40 | $ 104,990 | $ 2,624.76 |
| Non-Medical Transp. | 60B,849 | 119 | $ 19,794 | $ 166.34 | 47 | $ 15,552 | $ 330.89 | 6 | $ 1,408 | $ 234.67 | 172 | $ 36,754 | $ 213.69 |
| Assisted Living | 60C | 279 | $ 4,604,975 | $ 16,505.28 | 472 | $ 6,225,169 | $ 13,188.92 | 11 | $ 168,732 | $ 15,339.31 | 762 | $ 10,998,876 | $ 14,434.22 |
| PCA Agency | 60D,84A | 3,166 | $ 90,353,224 | $ 28,538.61 | 766 | $ 8,092,987 | $10,565.25 | 3 | $ 81,288 | $ 27,096.12 | 3,935 | $ 98,527,499 | $ 25,038.75 |
| Minor Home Modificatio | 60E,84B | 73 | $ 303,366 | $ 4,155.70 | 4 | $ 13,832 | $ 3,457.99 | 0 | $ - | | 77 | $ 317,198 | $ 4,119.45 |
| Assistive Technology | 60F,84C | 161 | $ 125,219 | $ 777.76 | 18 | $ 13,156 | $ 730.88 | 0 | $ - | | 179 | $ 138,374 | $ 773.04 |
| PCA Individual | 60G | 479 | $ 11,854,535 | $ 24,748.51 | 113 | $ 1,356,597 | $ 12,005.28 | 0 | $ - | | 592 | $ 13,211,131 | $ 22,316.10 |
| **Sub - Total (c)** | | **13,178** | **$ 227,947,913** | **$ 17,297.61** | **4,738** | **$ 38,536,608** | **$ 8,133.52** | **624** | **$ 4,680,555** | **$ 7,500.89** | **18,540** | **$ 271,165,077** | **$ 14,625.95** |
| **Home Health Services (e)** | | **13,178** | **$ 58,096,366** | **$ 4,408.59** | **4,738** | **$ 5,965,474** | **$ 1,259.07** | **624** | **$ 666,790** | **$ 1,068.57** | **18,540** | **$ 64,728,629** | **$ 3,491.30** |
| **Total - Comm. Svcs.** | | **13,178** | **$ 286,953,418** | **$ 21,775.19** | **4,738** | **$ 45,746,275** | **$ 9,655.19** | **624** | **$ 5,381,280** | **$ 8,623.85** | **18,540** | **$ 338,080,974** | **$ 18,235.22** |

(a) All Screening Services and Waiver Services expenditures and unduplicated recipients are from a Data Warehouse query."
*(b) Avg. Montly Cost per Recipient reflects the Annual Expenditures divided by the Total Unduplicated Count of Recipients.*
*(c) Source of the subtotal undpulicated recipients is the figure shown for "Case Management".*
*(d) Subtotal undpulicated recipients for Home Health Services is equal to the figure shown for "Case Management".*
*(e) Home Health Expenditures for Title XIX and 1915i Recipients are estimated, since these costs do not appear on the 613T-ACU*

| Table 2-3. Five Most Expensive Services by Annual Cost Per Recipient: CHCP | | | |
|---|---|---|---|
| **Service** | **Annual Recipients** | **Annual Expenditures** | **Annual Cost Per Recipient** |
| Personal Care Assistant (Agency provides staff) | 3,935 | $98,527,499 | $25,039 |
| Personal Care Assistant (Recipient directly hires staff) | 592 | $13,211,131 | $22,316 |
| Assisted Living | 762 | $10,998,876 | $14,434 |
| Adult Day Health | 2,134 | $15,827,700 | $7,417 |
| Companion | 8,999 | $47,844,061 | $5,317 |
| Source: Department of Social Services | | | |

In addition, two of the most popular services provided to CHCP recipients were personal emergency response alarms (22,374 annual recipients), which had a per-client cost of $199 annually, and meals for 10,490 recipients costing $947 annually per recipient.

## Findings About CHCPE Cases Opened in 2012

- The majority of CHCPE participants (91 percent) were receiving services under Category 2 or 3
- Slightly over half the cases that opened in 2012 remained open in 2016
  - Category 1 cases had the highest percent of open cases (57 percent) and Category 2 the lowest percent (46 percent)
- Almost one-quarter of Category 2 cases entered a long-term care facility, compared with one in ten in Category 1 and one in five in Category 3
- On average, CHCPE participants had five ADLs—the most prevalent were bathing and dressing related needs
  - Category 1 and 2 participants had the greatest percent with need for assistance with all seven ADLs
  - One-third of Category 5 participants had no need for assistance with any ADLs
- There were 308 critical incidents recorded for the 4,848 CHCPE cases opened in 2012
  - 71 required an investigation, often for critical incidents related to alleged abuse, funds misappropriation, and alleged crimes
  - It is recommended that critical incidents and complaints received independently by DSS and DPH be communicated across the two agencies

## CHCPE Data Analysis Methodology

PRI staff examined the Connecticut Home Care Program for Elders (CHCPE) using web-based data maintained by the company ASCEND. The experience of a group of participants who submitted applications to CHCPE in the same year may be analyzed to determine outcomes for the cohort over subsequent years. Given that the median number of months cases were open for various CHCPE waivers ranged from 17 to 48 months, PRI staff chose to study all CHCPE applicants in calendar year 2012 and their outcomes over the subsequent four year period, through to September 30, 2016.

## Description of the 2012 Cohort

There were 4,484 cases that opened in calendar year 2012 and were assigned to a CHCPE waiver category. Table 2-4 shows the demographic characteristics for this 2012 cohort. Some differences are:

- Category 5 had some of the youngest participants (46% were 65-69 years old) and Category 2 had some of the oldest participants (55% were at least 85 years old)
- Category 1 was somewhat more likely to have male participants
- Category 2 participants were most likely to be widowed (60 percent) and Category 5 participants—most likely due to their relatively younger age--least likely to be widowed (27 percent)

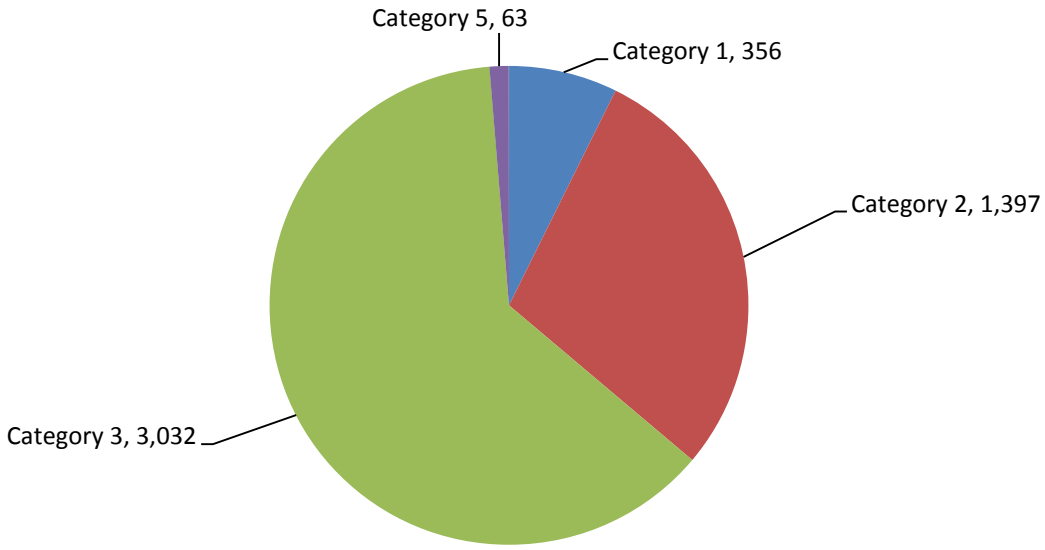
**Table 2-4. CHCPE Cases Opened in 2012: Participant Demographics**

| ***Demographic*** | ***CHCPE Category*** | | | | ***Total (N=4,848)*** |
|---|---|---|---|---|---|
| | **1 (n=356)** | **2 (n=1,397)** | **3 (n=3,032)** | **5 (n=63)** | |
| Age at Application | | | | | |
| 65-69 | 14.9% | 4.7% | 20.0% | 46.0% | 15.6% |
| 70-74 | 17.2% | 7.0% | 15.2% | 28.6% | 13.2% |
| 75-79 | 16.1% | 12.9% | 15.3% | 12.7% | 14.6% |
| 80-84 | 18.0% | 20.8% | 17.2% | 9.5% | 18.2% |
| 85-89 | 18.0% | 24.5% | 16.8% | 3.2% | 18.9% |
| 90+ | 15.8% | 30.1% | 15.5% | 0.0% | 19.5% |
| | | | | | |
| Gender | | | | | |
| Male | 37.6% | 30.1% | 30.7% | 31.7% | 31.1% |
| Female | 62.4% | 69.9% | 69.3% | 68.3% | 68.9% |
| | | | | | |
| Marital Status | | | | | |
| Married | 20.9% | 19.2% | 22.2% | 18.3% | 21.2% |
| Separated | 2.0% | 0.7% | 2.1% | 8.3% | 1.8% |
| Divorced | 22.0% | 11.5% | 17.0% | 26.7% | 15.9% |
| Single, never married | 15.1% | 8.3% | 13.9% | 20.0% | 12.4% |
| Widowed | 40.0% | 60.3% | 44.8% | 26.7% | 48.7% |

Source: PRI staff analysis of ASCEND database.

The majority of CHCPE participants (91 percent) were receiving services under Category 2 or 3 (Figure 2-1).

**Figure 2-1. CHCPE Category for Cases Opened in 2012**




## Outcomes for Cases Opened in 2012

Table 2-5 shows the status for the cases that opened in calendar year 2012 and were assigned to a CHCPE waiver category.

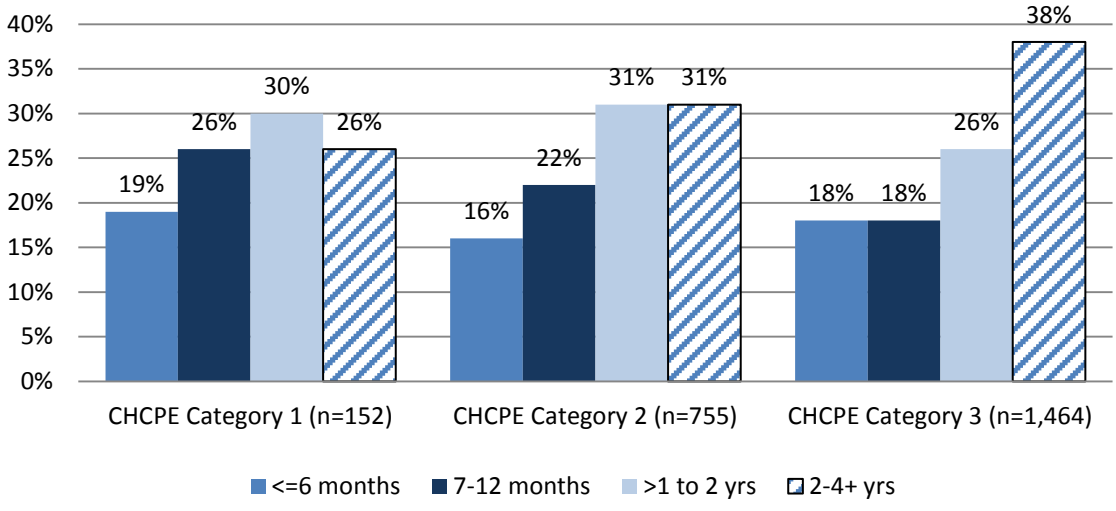
- Slightly over half the cases (51 percent) that opened in 2012 remained open in 2016.
- Category 2 participants were more likely to have closed than the other categories.
- 355 cases (7 percent) closed in the same year they opened.
- The greatest number of closures occurred one year later, in 2013 (752, or 16 percent).

| Table 2-5. Status of CHCPE Cases that Opened in Calendar Year 2012 | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***Category*** | ***Closed in 2012*** | ***Closed in 2013*** | ***Closed in 2014*** | ***Closed in 2015*** | ***Closed in 2016[b]*** | ***Total Closed*** | ***Cases Still Open*** |
| CHCPE Category 1 (n=350) | 31 | 59 | 30 | 12 | 20 | 152 (43%) | 198 (57%) |
| CHCPE Category 2 (n=1,389) | 113 | 273 | 178 | 127 | 64 | 755 (54%) | 634 (46%) |
| CHCPE Category 3 (n=3,019) | 211 | 419 | 345 | 288 | 201 | 1,464 (48%) | 1,555 (52%) |
| CHCPE Category 5 (n=63) | 0 | 1 | 5 | 3 | 2 | 11 (8%) | 52 (82%) |
| Total (N=4,821)[a] | 355 (7%) | 752 (16%) | 558 (12%) | 430 (9%) | 287 (6%) | 2,382 (49%) | 2,439 (51%) |

[a]Closed data missing for 128 cases.
[b]2016 closure information available through to September 30, 2016.

Figure 2-2 provides a breakout of the median length of time open for the Category 1-3 closed cases. There were more Category 3 cases that had closed after 2-4+ years (38 percent) compared to Category 1 and 2 cases (30 percent and 31 percent, respectively).

**Figure 2-2. Median Number of Months CHCPE 2012 Cases Had Been Open Prior to Closing**




Source: ASCEND database and PRI staff analysis.

Reason for Closure. The 13 possible reasons for closure are shown for each of the four CHCPE categories in Table 2-6.

- Combined, the individual died or entered a long-term care facility due to health accounted for four out of five CHCPE closures (81 percent).
- Compared to Category 2 and 3 participants, closures for Category 1 and 5 participants were more often attributed to refusal of services and relatively less often to entering LTC due to health.
- Very few cases closed because the care plan exceeded cost limits, the individual became ineligible due to level of care, or due to lack of services.

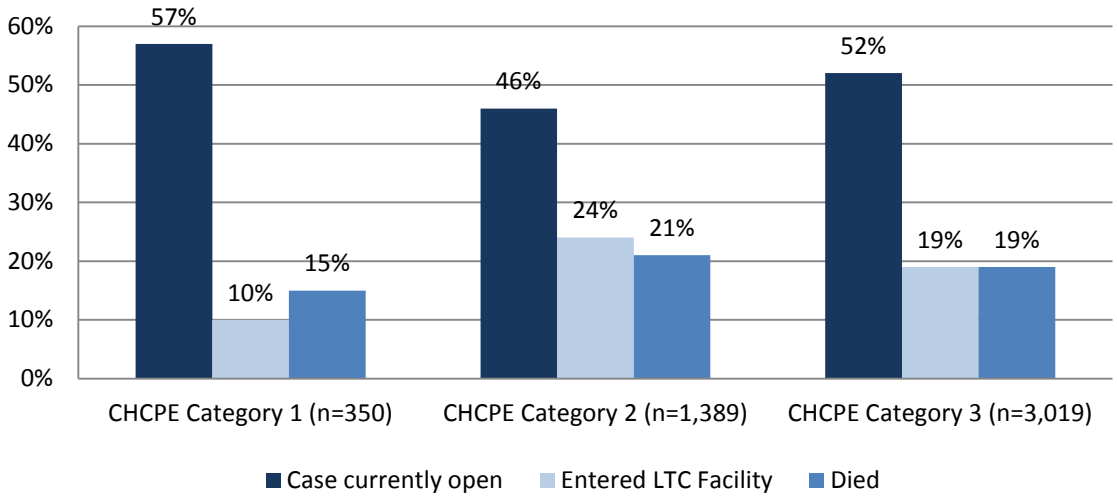
**Table 2-6. Reason for Closure of CHCPE Cases Opened in 2012: By Category**

| *Reason for Closure* | *Category 1* | *Category 2* | *Category 3* | *Category 5* | *Total* |
|---|---|---|---|---|---|
| Died | 52 (34%) | 292 (39%) | 572 (41%) | 1 (14%) | 917 (40%) |
| Entered LTC facility due to health | 33 (21%) | 290 (39%) | 482 (35%) | 1 (14%) | 806 (35%) |
| Entered LTC facility due to client choice | 4 (3%) | 43 (6%) | 88 (6%) | 0 | 135 (6%) |
| Refused services | 30 (20%) | 26 (4%) | 62 (4%) | 3 (43%) | 121 (5%) |
| Moved out of state | 14 (9%) | 19 (2%) | 80 (6%) | 1 (14%) | 114 (5%) |
| Non-compliance with contribution requirements | 10 (6%) | 20 (3%) | 5 (<1%) | 0 | 35 (2.0%) |
| Hospital stay exceeds hospital limits | 1 (1%) | 10 (1%) | 16 (1%) | 0 | 27 (1%) |
| Became financially ineligible | 1 (1%) | 7 (1%) | 7 (<1%) | 0 | 15 (1%) |
| Lack of services | 2 (1%) | 0 | 2 (<1%) | 0 | 4 (<1%) |
| Became ineligible due to level of care | 1 (1%) | 2 (<1%) | 1 (<1%) | 0 | 4 (<1%) |
| Care plan exceeded Social Service cost limit | 1 (1%) | 0 | 0 | 0 | 1 (0%) |
| Care plan exceeded total cost limit | 0 | 0 | 1 (<1%) | 0 | 1 (0%) |
| Other | 5 (3%) | 41 (6%) | 66 (5%) | 1 (14%) | 113 (5%) |

Source: ASCEND Database and PRI Staff Analysis.

Figure 2-3 shows the three most common outcomes for the most prevalent CHCPE categories. As noted in Table 2, Category 1 has a higher percent of open cases compared with Categories 2 and 3. Almost one-quarter of Category 2 cases in the 2012 cohort entered a long-term care facility, compared with one in ten in Category 1 and one in five in Category 3. Approximately one in five of the 2012 cohort in Categories 2 and 3 closed due to death, a slightly less common occurrence for Category 1 participants.

**Figure 2-3. Most Common Outcomes for CHCPE Categories for Cases Opened in 2012**




Source: ASCEND database and PRI Staff Analysis

Activities of Daily Living. Applicants are assessed on seven Activities of Daily Living (ADLs). Table 2-7 shows the ADLs present for each of the CHCPE categories.

- On average, CHCPE participants had five ADLs
- The most prevalent ADLs were bathing and dressing
- Category 2 had the highest average number of ADLs and Category 5 the lowest average number of ADLs

**Table 2-7. Activities of Daily Living for CHCPE Category Participants: Cases Opened in 2012**

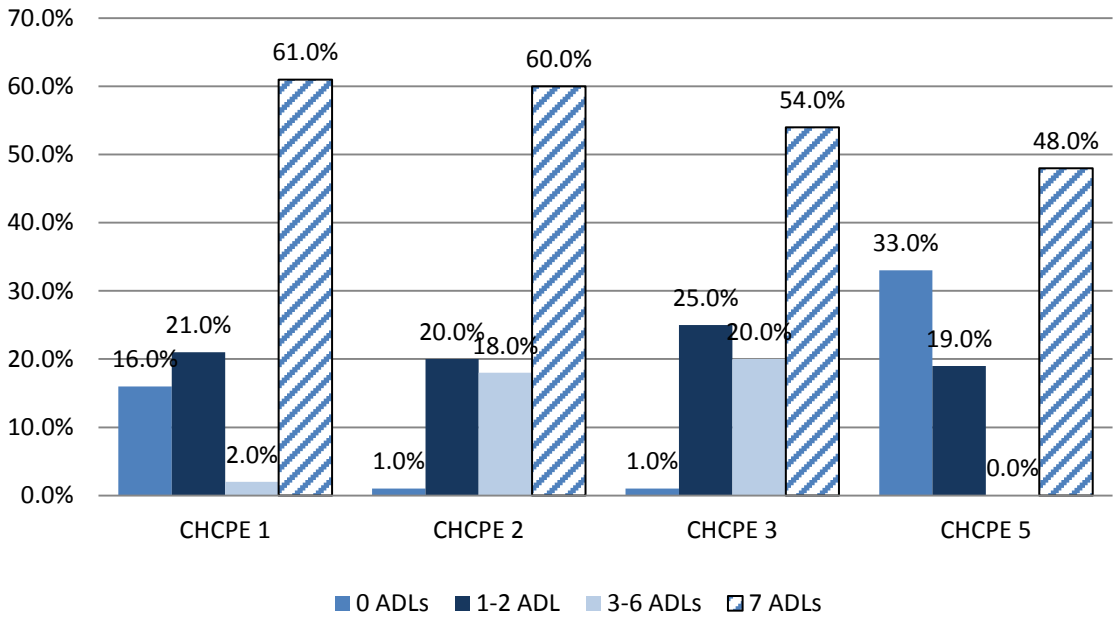
| ***Need Help with ADL:*** | ***CHCPE 1*** | ***CHCPE 2*** | ***CHCPE 3*** | ***CHCPE 5*** | ***Total*** |
|---|---|---|---|---|---|
| Bathing | 79% | 98% | 98% | 62% | 96% |
| Dressing | 65% | 86% | 85% | 48% | 83% |
| Bladder | 64% | 75% | 68% | 52% | 70% |
| Toileting | 60% | 70% | 65% | 48% | 66% |
| Transferring | 61% | 69% | 65% | 50% | 65% |
| Bowel | 60% | 67% | 60% | 50% | 62% |
| Eating | 61% | 66% | 60% | 48% | 61% |
| Avg # ADLs | 4.6 | 5.3 | 5.0 | 3.6 | 5.1 |

Source: ASCEND database and PRI staff analysis.

Figure 2-4 shows the percent of each CHCPE category with the number of Activities of Daily Living.

- Categories 1 and 2 had the greatest percent with need for assistance with all seven ADLs
- One-third of Category 5 participants had no need for ADLs identified
- Categories 2 and 3 had the greatest percent with need for assistance with 3-6 ADLs

**Figure 2-4. ADLs Per CHCPE Category**




Source: ASCEND Data and PRI Staff Analysis.

Instrumental Activities of Daily Living. Applicants were also assessed on nine Instrumental Activities of Daily Living. Table 2-8 shows the IADLs present for each of the CHCPE categories.

- On average, CHCPE participants had eight IADLs.
- Approximately nine in ten needed assistance with all but two of the IADLs (mobility, and using telephone).
- Category 2 had the highest average number of IADLs and Category 5 the lowest average number of IADLs.

| Table 2-8. Instrumental Activities of Daily Living for CHCPE Cases Opened in 2012 | | | | | |
|---|---|---|---|---|---|
| ***Need Help with IADL:*** | ***CHCPE 1*** | ***CHCPE 2*** | ***CHCPE 3*** | ***CHCPE 5*** | ***Total*** |
| Planning/preparing meals | 91% | 99% | 98% | 97% | 98% |
| Doing light housework | 96% | 99% | 98% | 91% | 98% |
| Shopping | 92% | 98% | 97% | 91% | 97% |
| Doing own laundry | 91% | 97% | 96% | 88% | 96% |
| Using transportation | 88% | 96% | 95% | 88% | 95% |
| Taking own medicine | 81% | 94% | 93% | 67% | 92% |
| Handling own money | 82% | 93% | 88% | 78% | 89% |
| Mobility | 68% | 78% | 73% | 50% | 74% |
| Using telephone | 62% | 68% | 63% | 52% | 64% |
| Avg # IADLs | 7.5 | 8.2 | 8.0 | 7.0 | 8.0 |
| Source: ASCEND database and PRI staff analysis. | | | | | |

Critical Needs. Besides ADLS and IADL assessments, there is also an assessment of critical needs. Table _ shows the number of critical needs for the initial assessment of the 2012 CHCPE cohort. CHCPE Category 1 participants are required to have 1 or 2 critical needs. Table 2-9 shows the initial assessment of the 2012 cohort for Category 1 had a small percentage with no identified critical needs; however, the majority had 1-2 critical needs (68.3 percent), and 29.2 percent had 3-7 critical needs.

| Table 2-9. Initial Critical Needs Assessment for CHCPE Cases Opened in 2012 | | | | | |
|---|---|---|---|---|---|
| **Number of Critical Needs:** | **CHCPE 1** | **CHCPE 2** | **CHCPE 3** | **CHCPE 5** | **Total** |
| 0 | 2.5% | 0.6% | 0.8% | 9.5% | 1.0% |
| 1 | 18.0% | 2.1% | 3.1% | 25.4% | 4.2% |
| 2 | 50.3% | 7.3% | 7.2% | 47.6% | 10.9% |
| 3 | 10.4% | 18.3% | 20.3% | 14.3% | 18.9% |
| 4 | 8.7% | 27.3% | 25.7% | 0% | 24.6% |
| 5 | 3.7% | 13.1% | 13.4% | 1.6% | 12.4% |
| 6 | 5.3% | 20.8% | 19.2% | 1.6% | 18.4% |
| 7 | 1.1% | 10.5% | 10.4% | 0% | 9.6% |
| Total | 356 | 1,397 | 3,032 | 63 | 4,848 |
| Source: ASCEND database and PRI staff analysis. | | | | | |

Critical Incidents

A total of 308 critical incidents were recorded for the 4,848 CHCPE cases that opened in 2012. There were 270 participants who had one type of critical incident recorded, 33 who had two types of critical incidents recorded, and five who had three types of critical incidents recorded. As shown in Table 2-10:

- The most prevalent type of critical incident was for emergency room visits or unplanned hospitalizations.
- There were also 82 instances of alleged abuse or neglect of a client.
- Category 3 had the most participants of all categories, and also the most critical incidents.
- 71 of the 308 critical incidents (23 percent) required an investigation, often for critical incidents related to alleged abuse, funds misappropriation, and alleged crimes.

**Table 2-10. Prevalence of Critical Incidents for CHCPE Cases Opened in 2012**

| Type of Critical Incident | CHCPE 1 | CHCPE 2 | CHCPE 3 | CHCPE 5 | Total |
|---|---|---|---|---|---|
| Emergency room visit or unplanned hospitalization | 5 | 27 | 139 | 2 | 173 |
| Alleged Abuse or neglect of client | 4 | 12 | 66 | 0 | 82 |
| Serious criminal allegation-client as victim | 0 | 6 | 27 | 0 | 33 |
| Misappropriation of client's funds | 2 | 3 | 24 | 0 | 29 |
| Unexpected absence of the primary caregiver | 0 | 0 | 8 | 0 | 8 |
| Untimely death | 1 | 1 | 6 | 0 | 8 |
| Serious criminal allegation-client as perpetrator | 0 | 4 | 2 | 0 | 6 |
| Missing person reported to police | 0 | 0 | 5 | 0 | 5 |
| Suicide attempt | 0 | 0 | 3 | 0 | 3 |
| Fire in residence with significant risk to client | 0 | 1 | 1 | 0 | 2 |
| Timesheet fraud | 0 | 0 | 2 | 0 | 2 |

Source: ASCEND database and PRI Staff Analysis.

In interviews with PRI staff, both DSS and the Department of Public Health (DPH) indicated that there is no direct communication between the two agencies when complaints are substantiated against employees of home health agencies.( DPH is responsible for licensing these agencies.) Thus, if DSS validates a critical incident involving client abuse, neglect, or

misappropriation of funds by a worker from a health care agency that DPH licenses, DPH is not informed. Similarly, if DPH substantiates a complaint involving an employee of a home health agency, that agency does not notify DSS. PRI staff believes that this is a potential gap in ensuring consumers of these services are protected from possible harm and therefore, **PRI staff recommends:**

> **The Department of Social Services and the Department of Public Health should develop a process to inform each other when certain complaints are verified by either agency and involve employees of home health agencies.**

# Chapter 3

## Money Follows the Person Demonstration Grant

Another major DSS funding source for individuals seeking to transition out of an institution and into the community is the Money Follows the Person Rebalancing Demonstration Grant. Known as MFP, it was established under the federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171). It supports states' efforts to rebalance their LTSS systems by providing financial incentives for moving people out of institutional care and back into the community. The purpose of the MFP demonstration was to find ways to remove barriers for people who were in nursing homes for at least 90 days and had barriers that prevented them from returning to the community. (The 90 day requirement is a federal regulation that was reduced from 180 days in 2010.) The person must be eligible for Medicaid on day 90 in an institution in order to be eligible for MFP.

Under MFP, states are offered an enhanced Federal Medical Assistance Percentage (FMAP) on demonstration services for individuals who have transitioned from institutions to the community. The enhanced federal match in Connecticut is 25 percent (so the state receives 75 percent reimbursement rather than 50 percent under Medicaid waiver programs) for the initial 365 days the person moves into the community.[1] On day 366 of the transition in the community, the person transitions to one of the other Medicaid waiver programs (or a Medicaid state plan program) and payment for services and services available are provided under that waiver or the state plan. At that time, federal reimbursement is reduced to 50 percent. In FFY 15, total expenditures (state and federal) were $35,683,742.

One major benefit of MFP is that it also allows states to provide additional transition services to individuals that are not covered under the Medicaid state plan or Medicaid Waiver programs if those services will assist in successful transitions. MFP pays for community care as well as various expenses that occur when a person moves back into a community setting, such as help with home modifications and rent and security deposits, along with one-time setup costs (i.e., furnishings) for a new apartment.

Based on an individual's needs, MFP provides the funds, services, and support so that an individual can successful transition into the community. Housing options include returning to the individual's own home, an individual apartment, assisted living, or a group home. Each person is assigned a Transition Coordinator that works with the individual and his or her care team on a one-to-one basis to develop a plan.

The Department of Social Services established five benchmarks to evaluate the success of the program. They are:

[1] If a person becomes re-institutionalized during the 365-day period, the MFP case is closed. If the person is able to transition back into the community after the case is closed, in any time period, the 365-day time period is started anew.

1. Transition 5,200 people from qualified institutions to the community

2. Increase dollars to home and community-based services

3. Increase hospital discharges to the community rather than to institutions

4. Increase probability of returning to the community during the six months following nursing home admission

5. Increase the percentage of long-term care participants living in the community compared to an institution

Evaluation of the performance of the program is carried out by UConn Health, Center on Aging. In addition to quarterly reports, the center publishes reports on transition challenges, closed cases, and surveys of individuals who have left institutions as a result of MPF.

*Staffing and resources***.** DSS contracts for staff with four Access Agencies (three area agencies on aging (AAAs), and Connecticut Community Care, Inc.) to engage people who live in nursing homes but would like to return to the community and assist in their transition back.[2] Responsibility is geographically split into five regions. Through these contracts, there are about 120 staff fully dedicated to MFP, who work with individuals residing in nursing homes seeking to transition back to the community. These staff work in teams with the goal of ensuring individuals are making informed choices. The staff involved in the transition process include:

- specialized care managers (SCMs);
- transition coordinators (TCs); and
- housing specialists.

It should be noted that in some regions, the three types of staff come from a only the Access Agency while in other regions, responsibility is split with Access Agencies having specialized case managers and AAAs having transition coordinator staff. In interviews with PRI staff, access agency, AAA, (and CIL staff) stated that this fragmented organizational structure could be problematic with staff from multiple organizations not always clearly communicating the needs of the client. Because of these concerns, **PRI staff recommends:**

**The Department of Social Services should establish a process to ensure information on transition plans and plans of care is shared among all Money Follows the Person team members when roles are split among multiple organizations.**

Once an Access Agency receives a referral from DSS/MFP Unit, a specialized care manager is the first point of contact with the nursing home resident. The care manager schedules a visit with the nursing home resident that must occur within 20 business days. At the visit, the

[2] The Western Area Agency on Agency serves as an additional Access Agency for the city of Waterbury only. Also, some of the Centers for Independent Living have staff housing specialist staff and are part of the MFP team.

care manager introduces the MFP program to the resident, discusses home and community-based options, and program eligibility, and if the resident is interested, obtains his or her informed consent, which allows the process to move forward. According to one of the Access Agencies, it typically takes about 20 business days to determine if a nursing home resident wants to sign the informed consent document, although it can take longer in some cases. If the resident chooses not to sign the informed consent document, the access agency is not reimbursed by DSS for the time the care manager explained the community options to the nursing home resident. According to access agency staff, this contact can be extensive and there is no process for reimbursement from DSS.

For those nursing home residents who do sign an informed consent agreement, the team responsible for the transition develops two plans – a plan of care that identifies the services that will be needed once the transition occurs (such as homemaker and companions), and a transition plan that focuses on the physical environment such as the need for housing and housing modifications. According to interviews with DSS and Access Agency staff, major barriers to successful transitions include:

- lack of housing;
- having a criminal background;
- physical health decline; and
- needing a very high level of services.

*Cost caps*. Unlike CHCP, each person's plan of care is based on the cost of his or her current nursing home and is the limit for services provided in the community. A person's actual budget, however, is determined by his or her needs and the person does not automatically get the maximum dollar limit if the person does not need it. (The budget does not include some transitional services, such as a furniture allowance and home modifications if necessary. In addition, individuals who need rental assistance become eligible for these programs also.) Under no circumstances however, can a person's plan of care exceed the cost cap of whichever waiver he or she will transition to on day 366 in the community. A listing of all the community plan of care cost caps is provided in Appendix C, with some waivers allowing for a community care plan that is 200 percent of the cost of care that a person is currently receiving in a skilled nursing facility or special care hospital.

Respite is also available under MFP. Reimbursement is allowed for respite provided in the home, in adult day centers, or in other settings. Provision of this service can make it easier for families who wish to see their loved one leave an institution and return home.

PRI staff was provided with a database containing information about MFP participants from the program's inception in December 2008 through to June 30, 2016. The purpose of the analysis was to identify factors influencing the transition of individuals out of nursing homes or other institutions into home and community settings. This chapter provides detailed results of this analysis. The key findings are now summarized.

## Factors Influencing MFP Nursing Home to Community Transitions

- Led by DSS over the past seven years, the **maturation of the MFP program** itself **resulted in significant improvements** in both the number of transitions and time needed to transition MFP participants into the community
- Since the inception of MFP, **nursing home residents have become increasingly older and sicker**, a challenge for future transitions
- The **MFP target populations served has changed**, with older adults--which accounted for over one-third of MFP participants in 2009/2010—now making up more than half 2014
- The **utilization of risk agreements** has not resulted in poorer transition outcomes despite some concerns from the field
- There are changes that can be made to **improve MFP program efficiencies** including establishing maximum time certain cases remain open, providing training on ADL/IADL assessments, and adequate transition preparation for individuals with certain risk factors
- There are changes that can be made to **improve MFP data collection** including clarifying how MFP referrals, transitions, and challenges are captured

### MFP Data Analysis Methodology

The University of Connecticut Health Center on Aging (UConn Health) provided a database to PRI staff of all 7,709 referrals to MFP from 12/4/2008 through 6/30/2016 that had a signed informed consent form.[3] While only cases with informed consent forms were provided to PRI, UConn Health has used other methodologies to count total MFP referrals.[4]

**Counting MFP referrals.** In contrast to the 7,709 referrals provided by UConn, "The Rebalancing Update" reported 11,601 applications to MFP during approximately the same time period. This higher figure included individuals who had not signed a consent form to participate in MFP. As this was the minimal standard used to provide the MFP database to PRI staff, PRI staff recommends:

> **The Department of Social Services should distinguish between individuals who signed Money Follows the Person (MFP) consent forms and individuals who did not sign MFP consent forms when reporting such data to the public since it overstates the number of people who were informed about MFP and decided to move forward with an informed consent document.**

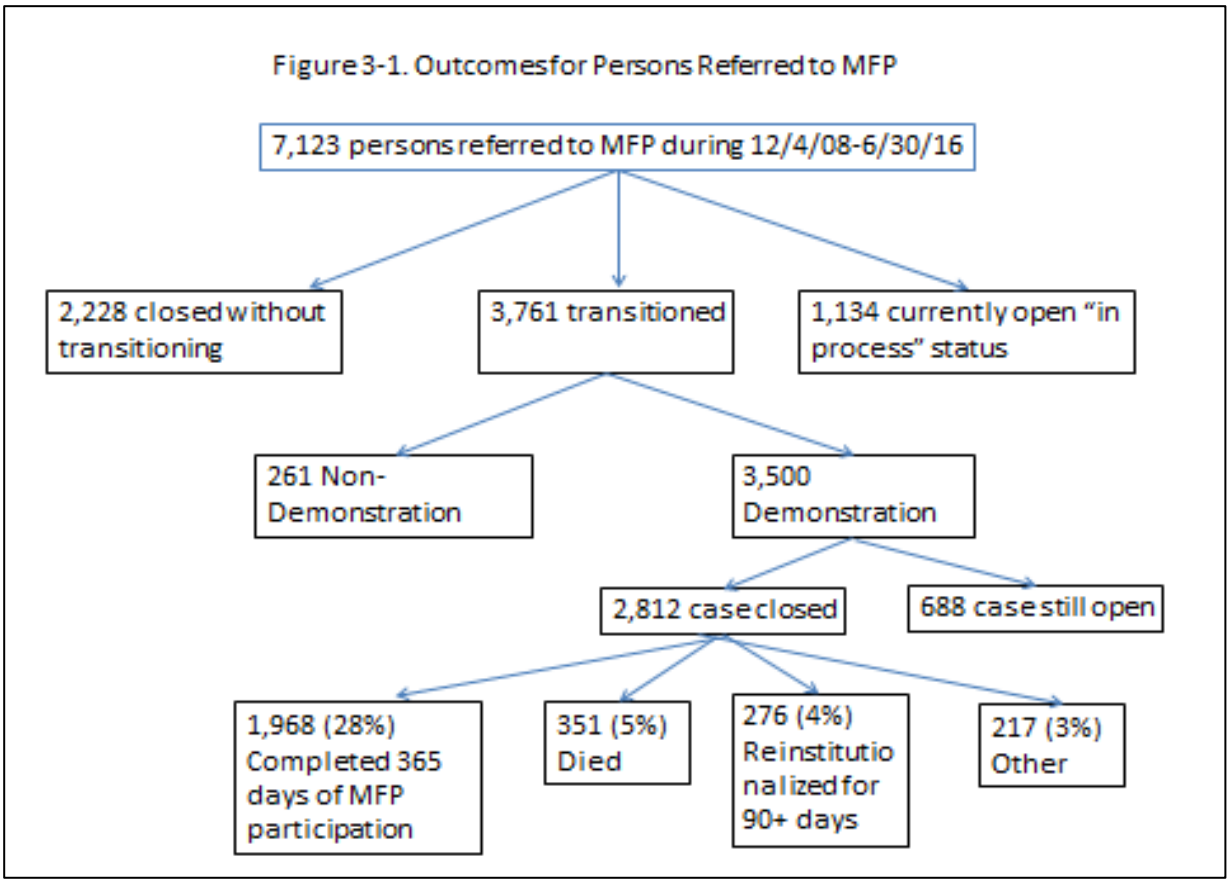
[3] Data was downloaded from MFP web-based database on 8/16/16 and is current/updated through to that date.
[4] Long-Term Services & Supports Rebalancing Updates September 2016. Connecticut Department of Social Services PowerPoint Presentation.

Related to the counting of MFP participants is the categorization of individuals as either MFP "demonstration" or "non-demonstration" consumers. In order to be eligible to be considered an MFP demonstration participant, an individual has to meet the following requirements:

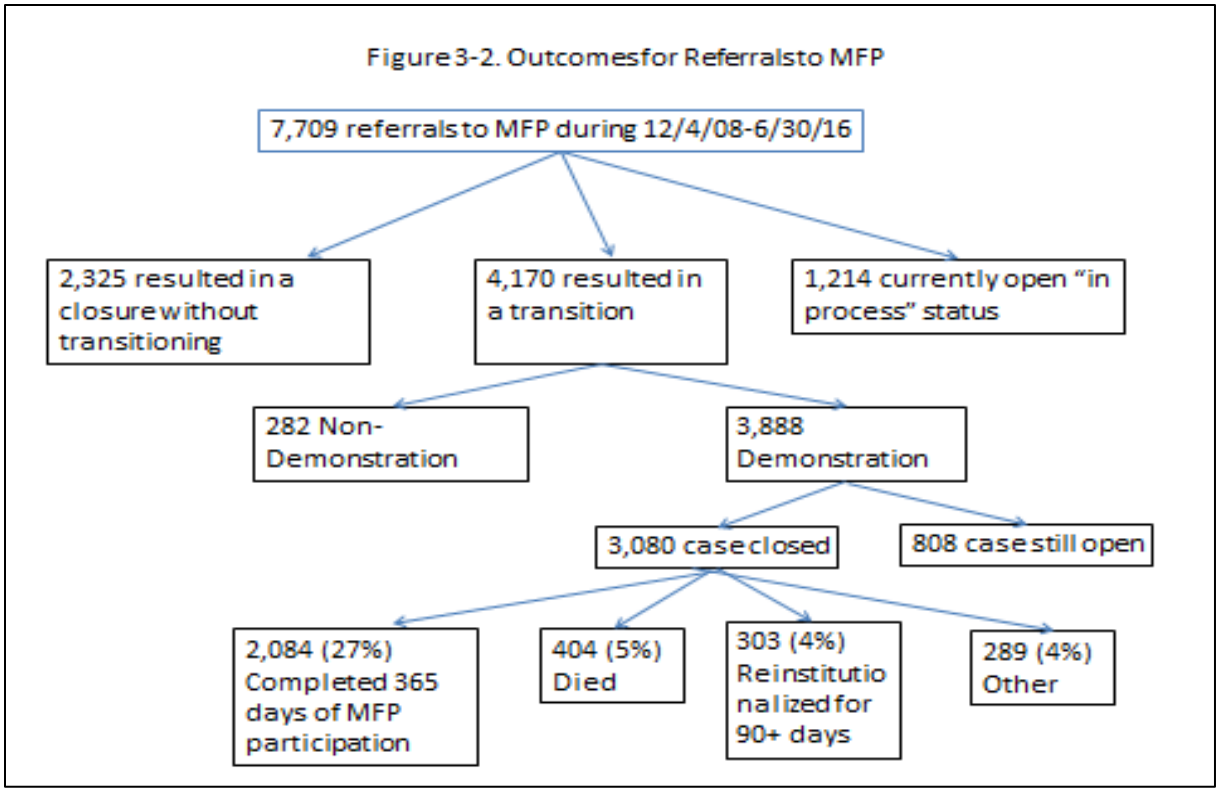
- Medicaid must be payor at time of discharge from institution
- Individual must have been institutionalized for at least 90 days
- Individual must transition to a qualified housing setting

Should any of these requirements not be met, then an individual was categorized as a non-demonstration participant at time of transition by DSS Central Office.[5]

**Referrals vs. Individuals.** The 7,709 referrals to MFP actually represented a total of 7,123 individuals because some individuals had multiple referrals. Most of these individuals, 6,595, were referred to MFP once (92.6% of 7,123), 475 referred twice (6.7%), 48 referred three times (0.7%), and 5 referred four times (0.1%). The distinction between MFP individuals and referrals is demonstrated in Figures 3-1 and 3-2, respectively.




[5] DSS Paul Ford email dated 8/4/16




While the overall proportions transitioning and remaining in the community, for example, are quite similar, the number of referrals inflates the individuals participating in MFP, and also the number of transitions that occurred, a benchmark of the MFP demonstration project. There are 409 more transitions when referrals rather than individual people are used for this calculation (3,761 people transitioned (Figure 3-1) and 4,170 referrals transitioned (Figure 3-2). PRI staff will use individuals rather than referrals for the remainder of this chapter.

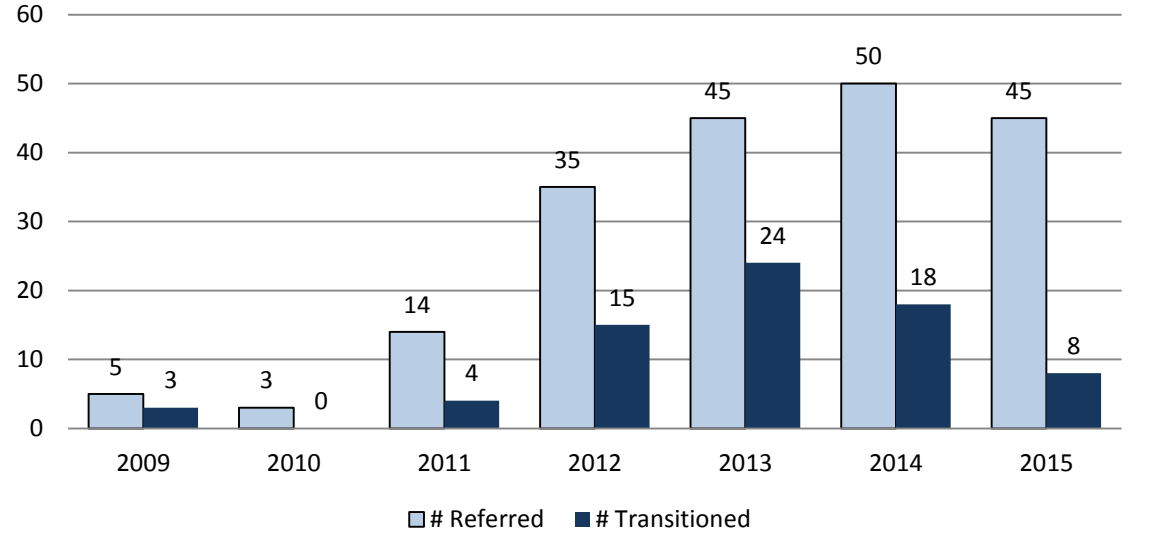
As discussed earlier, the original MFP Benchmark #1 is to transition 5,200 people from qualified institutions to the community. Since this study found the same individual may transition multiple times, in order to accurately measure progress in meeting the benchmark in number of individuals transitioning back into the community, PRI staff recommends:

> **The Department of Social Services should monitor and report separately on an unduplicated count of the number of people who transitioned to the community under MFP and the number of <u>referrals</u> that result in transitions to the community.**

**MFP referrals from MDS Section Q.** The Centers for Medicare and Medicaid require nursing homes to periodically ask residents if they wish to return to the community. From 2009-2016, there were 206 nursing home participants referred to MFP because they responded affirmatively to the question "Do you want to speak to someone about the possibility of returning to the community?" (referred to as MDS Section Q). Figure 3-3 shows the number of these referrals each year and how many transitioned into the community. Note for 2015, the chart does

not show the additional 18 in the process of transitioning into the community, nor the nine referrals to date in 2016, due to insufficient time to transition. The chart shows a relative increase in the number of referrals to MFP from this source.

**Figure 3-3. Number Referred to MFP Through MDS Section Q and Number Transitioned by Referral Year**




In 2015, for example, of the 43 referrals that came from Section Q, 15 of them (35 percent) came from a single facility (Silver Springs Care Center in Meriden), with 2 facilities each having two referrals, and 24 facilities each having 1 referral. The remaining nursing homes presumably had no referrals. It is curious that some facilities would have 35 percent of the referrals from Section Q while others would have none. PRI staff recommends:

**The Department of Social Services should determine if all the referrals from the federal Long-Term Care Minimum Data Set Section Q are being captured, and if not, provide training on how to more accurately code source of referral to MFP.**

**Further, concerns have been raised about whether the question is always asked of nursing home residents as required by federal law. As part of its role of providing nursing home oversight, the Department of Public Health should monitor whether Section Q is being asked of nursing home residents.**

Number of transitions over time. DSS made significant improvements in both the number of transitions and time to transition for MFP participants over the seven years examined (Figure 3-4). ***As the MFP demonstration evolved, there was more than a 50 percent reduction in the median (or middle-most) number of days from signed consent form to transition into the community.*** Figure 4 also shows that this reduction in days to transition was maintained despite the dramatic increase in the number of transitions. After studying how to improve the number of

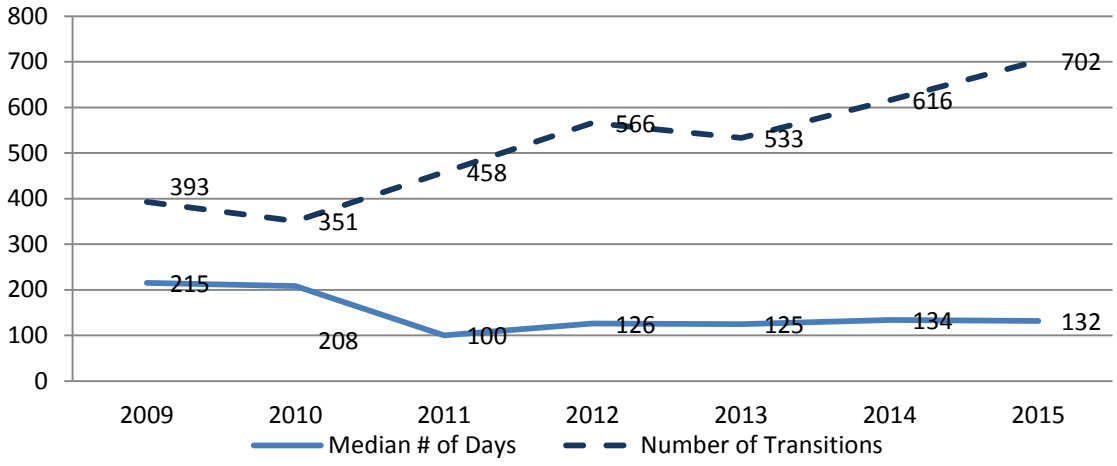
transitions, DSS made several changes in 2011 to the MFP program and policies that contributed to this reduction in transition time including increased staff including dedicated care management positions for MFP participants, and implementation of participant risk agreements.

DSS also reported that CMS revised the MFP protocol was revised in 2009, reducing the required minimum number of days in institutional care/ nursing home from 180 days to 90 days. These trends may have been impacted as the new protocol was implemented.

Additionally, changes in 2014 that may have also contributed to maintenance of the reduced length of time to transition despite the increase in number of MFP participants include:

- implementation of a new transition process, using Specialized Care Managers (SCMs);
- increased the number of Housing Coordinators (HCs); and
- created new MFP structure in five regions, each having between two to eight teams, depending on the number of referrals, consisting of one Specialized Care Manager, two Transition Coordinators, and one Housing Coordinator, with each having a separate focus on how to work with nursing home residents and assist in their transition to the community.

**Figure 3-4. Number of Transitions and Time to Transition for Demonstration and Non-Demonstration Combined**




Source: MFP database and PRI staff analysis .

**Demonstration vs. Non-Demonstration.** As noted earlier, MFP participants are categorized as either demonstration or non-demonstration participants. In examining the 7,123 MFP individuals (using information from their first referrals, if multiple referrals existed), there

were 5,947 individuals categorized as demonstration (84 percent), 341 individuals categorized as non-demonstration (5 percent) and 835 individuals with no categorization (12 percent) (Table 3-1). The table shows:

- although small in number, individuals in the non-demonstration category were most likely to transition;
- few individuals in the "blank" category transitioned;
- overall, approximately half (53 percent) of MFP participants transitioned; and
- although individuals are categorized as demonstration or non-demonstration at time of transition, 1,656 individuals were given a classification, but did not transition.

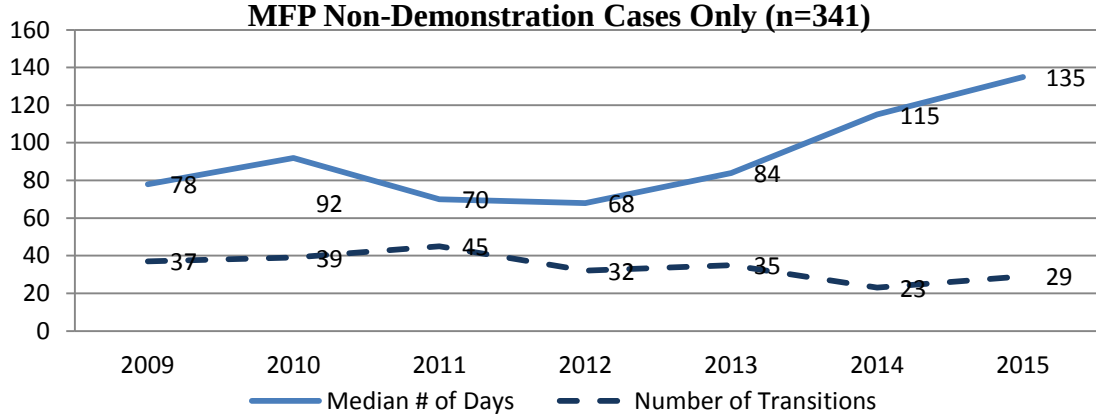
**Table 3-1. Transition Outcome for MFP Program Category**

| *MFP Program Category* | *No, did not transition* | *Yes, transitioned* | *In process of transitioning* | *Total* |
|---|---|---|---|---|
| Blank | 741 (89%) | 35 (4%) | 59 (7%) | 835 (100%) |
| Demonstration | 1,582 (27%) | 3,465 (58%) | 900 (15%) | 5,947 (100%) |
| Non-Demonstration | 74 (22%) | 261 (76%) | 6 (2%) | 341 (100%) |
| Total | 2,397 (34%) | 3,761 (53%) | 965 (14%) | 7,123 (100%) |

Source: MFP database and PRI staff analysis (program by TransitionYN).

Examining just the 341 non-demonstration cases, Figure 3-5 shows a somewhat decreasing number of transitions, but an increasing median number of days from signed consent form to transition into the community for this similar or reduced annual number of cases.

**Figure 3-5. Number of Transitions and Time to Transition for MFP Non-Demonstration Cases Only (n=341)**




Source: MFP database and PRI staff analysis.

The distinction between MFP demonstration and non-demonstration reportedly does not occur until the individual leaves the nursing home, triggering a difference in the billing for services. In actuality, however, for some individuals who never transition, this distinction of

demonstration vs. non-demonstration occurs as well. No one is considered an MFP participant until the day they transition, at which point DSS begins to bill the federal government. MFP allows the 25 percent of 75 percent federal matching funds to be reinvested into the Medicaid clients that would cover these non-traditional Medicaid services for 180 days, such as access to a transition coordinator. However, non-demonstration participants do not have access to other demonstration services such as substance abuse intervention and peer support.

Conflicting information was provided by DSS and access agencies regarding the number of days of post-transition support received by non-demonstration participants (180 vs. 365 days) compared with the typical 365 days provided to MFP demonstration participants. PRI staff recommends:

**The Department of Social Services should clarify with access agencies the supports and services available to non-demonstration participants.**

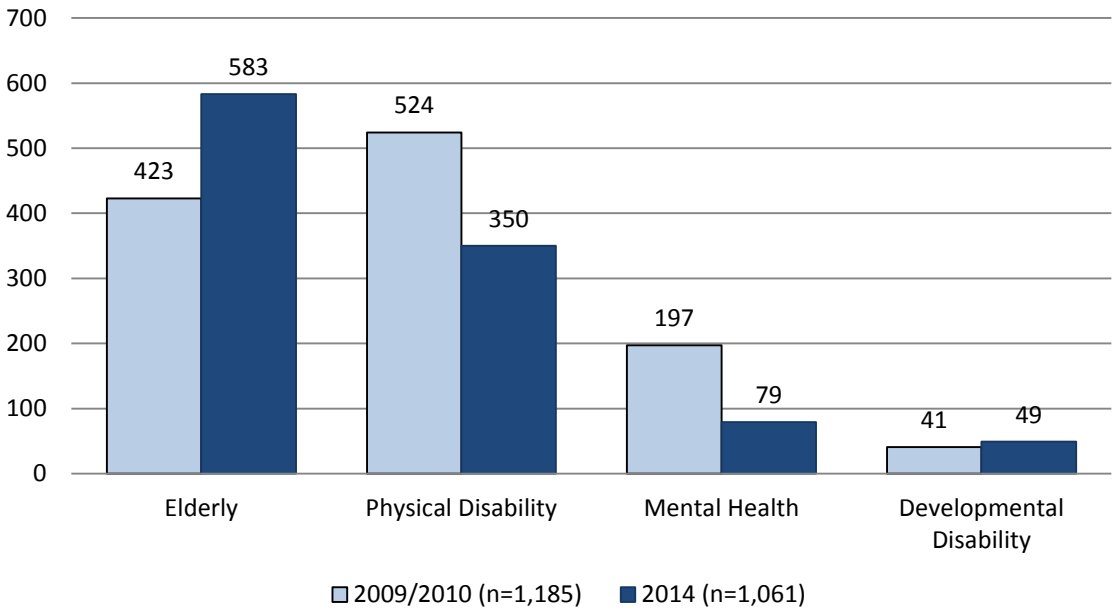
Because non-demonstration cases appear to differ from demonstration and "blank" participants in the time needed to transition and quantity and type of services available, and also in challenges to transitioning (See Appendix D), the non-demonstration cases will be excluded from the remainder of the analyses in this chapter. The resulting cases will be referred to as "MFP demonstration participants" and will include the "blank" participants, as these individuals did not transition to non-qualified housing settings, or remain institutionalized for less than 90 days prior to transition, two of the three reasons for being categorized as a non-demonstration participant.

**Target population categories.** MFP participants are placed into one of four categories: older adults; physical disability; mental health; and developmentally disabled. The reason for this is to indicate what Medicaid waiver the person will be eligible for after 365 days.

The largest percent of individuals seeking to transition are in the older adults and physical disability categories. Figure 3-6 shows there have been changes in who is served by the MFP demonstration project. For example, there has been a relative increase in older adults and individuals with developmental disabilities, and a relative decrease in individuals with physical disabilities and mental health issues. While the 423 older adults served in 2009/2010[6] accounted for over one-third of the participants served by MFP, the 583 older adults accounted for more than half the MFP demonstration participants who completed informed consent forms in 2014.

[6] 2009 and 2010 represent the earlier years of MFP, and combined, have a similar number of MFP participants as occurred in the later year of 2014.

**Figure 3-6. Change in Target Populations Served by MFP Demonstration Project**




This information missing for 22 participants.
Source: MFP Database and PRI Staff Analysis.

## Transition Outcomes for MFP Demonstration Participants

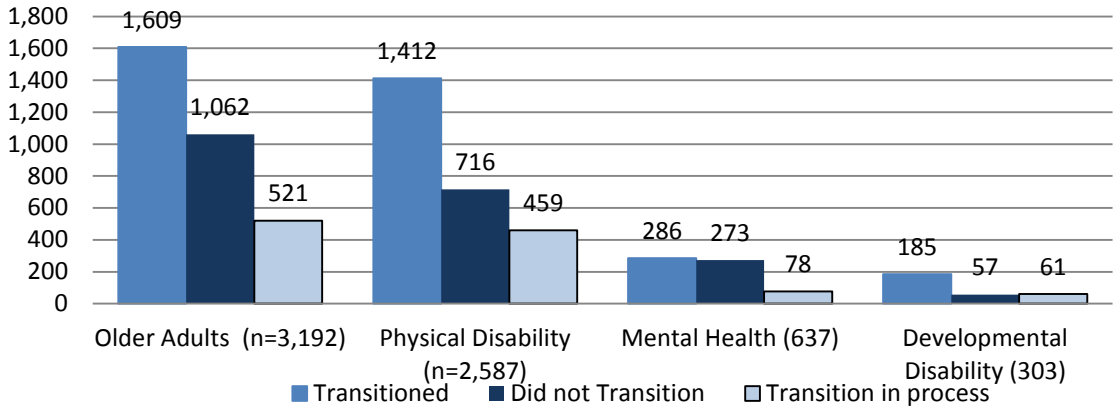
There were two key outcomes examined: presence/absence of transition; and remained in community post-transition for 365 days, the maximum allowed under the MFP program.

Of the 6,782 MFP demonstration participants analyzed for this study, 3,500 transitioned (52 percent), 2,155 closed without transitioning (32 percent), and 1,127 are in the process of transitioning (17 percent)[7]. This section describes transition status for target populations, waiver services received, and informal caregiver supports for individuals seeking to transition. Barriers to transitioning including time in facility, activities of daily living and instrumental activities of daily living will also be described.

**Transition Status for Target Populations**. Figure 3-7 shows the outcome for the cases for each of the four target populations. The majority of transitioners were older adults or physically disabled. Those MFP demonstration participants with developmental disabilities, while a small number, had the highest percent that had transitioned into the community (61 percent), and mental health the lowest percent (45 percent).

[7] Percents may not total to 100% due to rounding.

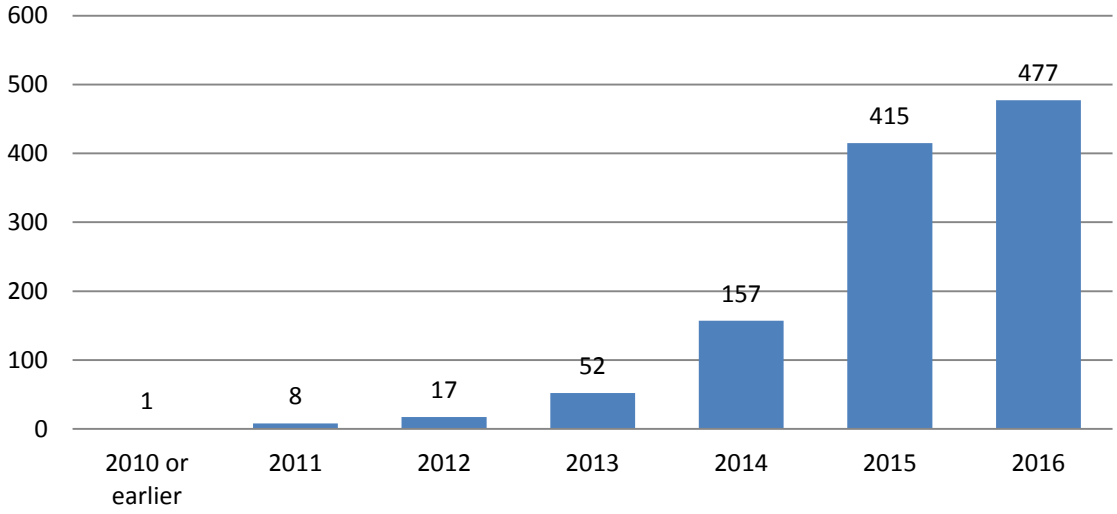
**Figure 3-7. Transition Status for Target Populations**




This information missing for 63 cases.
Source: MFP database and PRI staff analysis.

**Number with Status of "Transition in Process."** Figure 3-8 shows the year the 1,127 individuals who have a status of "Transition In Process" signed their informed consent forms, indicating when their participation in MFP demonstration program began.

**Figure 3-8. Years in Which "Transition In Process" Cases Signed Informed Consent forms for MFP Program**




Source: MFP Database and PRI Staff Analysis.

As shown in the figure, 77 individuals who signed MFP informed consent forms during 2011-2013 and currently have a status of "transition in process." PRI staff is not aware of a guideline regarding the maximum amount of time a case should remain open without transitioning. Given that some of these cases are three or more years old, and a person's health status or level of functioning could have changed significantly, PRI staff recommends:

**The Department of Social Services should establish a maximum length of time that a case with a status of "Transition in Process" should remain open.**

**Reason for Closure for Non-Transitioners.** Of the cases that closed without transitioning, the reasons for closure are shown in Table 3-2. Overall, the two most frequent reasons for closure were that the participant changed his or her mind and decided to remain in the facility, or the participant died. (Note, there were 49 (2.3 percent) participants who closed because they transitioned to the community without the MFP program, despite signing an informed consent form to participate in the program).

**Table 3-2. Reasons for Closure for MFP Participants not Transitioning into the Community**

| ***Reason for Closure without Transitioning*** | ***MFP Participants (n=2,155)*** |
|---|---|
| Participant changed his or her mind and would like to remain in the facility | 22.6% |
| Died | 21.9% |
| Participant would not cooperate with MFP process | 13.3% |
| Exceeds physical health needs of MFP program | 12.9% |
| Conservator of Person/Guardian refused participation | 12.4% |
| Exceeds mental health needs of MFP program | 4.6% |
| Participant left without approved transition plan | 2.3% |
| Participant moved out of state | 2.4% |
| Nursing home closed and person moved to another facility | 0.9% |
| Person hospitalized 90 days with no discharge date | 0.2% |
| Other | 6.3% |

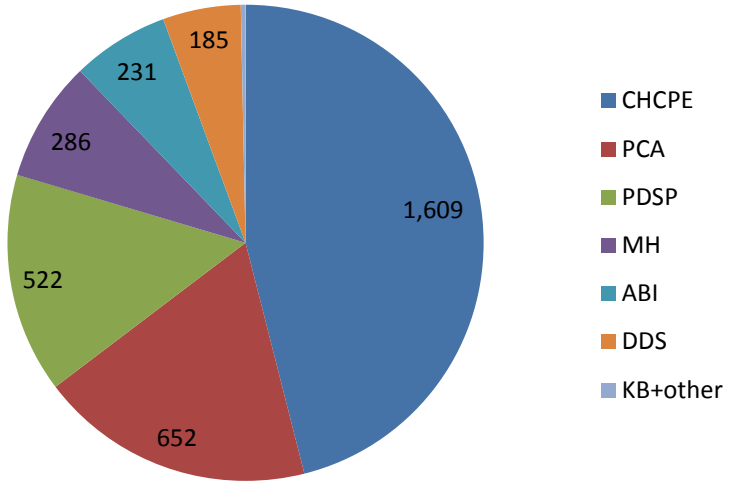
Source: MFP database and PRI staff analysis.

**Waiver services received when transitioned.** For the 365 days MFP participants are living in the community, their expenses are covered by the MFP demonstration grant. PRI staff was told that on Day 366, the individual seamlessly transitions to a Medicaid waiver program. Figure 3-9 shows the waivers for the 3,500 MFP participants that transitioned into the community (Missing data for 4 participants).

On Day 366, all older adults transitioned to a CHCPE waiver, all in the mental health target population transitioned to a DMHAS waiver, and all in the developmental disability target population transitioned to a DDS waiver. The physical disability target population, however, had approximately half (47 percent) transition to a Personal Care Assistance (PCA) waiver, with the

remainder receiving the Physical Disability State Plan (PDSP) (37 percent of physical disability target population), Acquired Brain Injury (ABI) (16 percent), and Katie Beckett or other waiver services (<1 percent).

**Figure 3-9. Waivers and State Plans for MFP Transitioners**




**Informal family supports.** Approximately 60 percent of the MFP demonstration transitioners and non-transitioners (i.e., closed without transitioning) provided information on contacts (n=3,423) they had living in the community. PRI staff developed categories for contacts, such as adult child (son or daughter), spouse, sibling, parent, other relative, or friend. In all instances, those who transitioned were significantly more likely to list a contact (Figure 3-10).

**Figure 3-10. Type of Contact Provided to MFP**

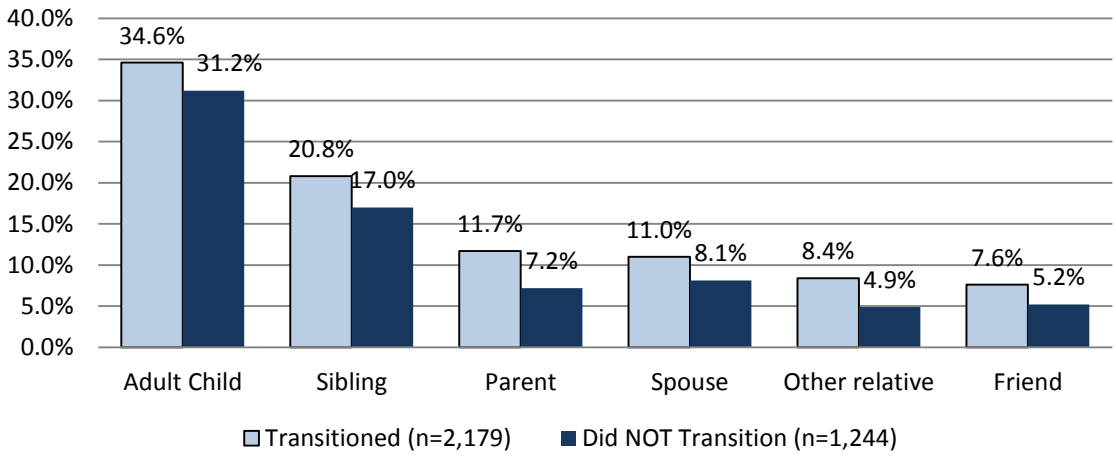
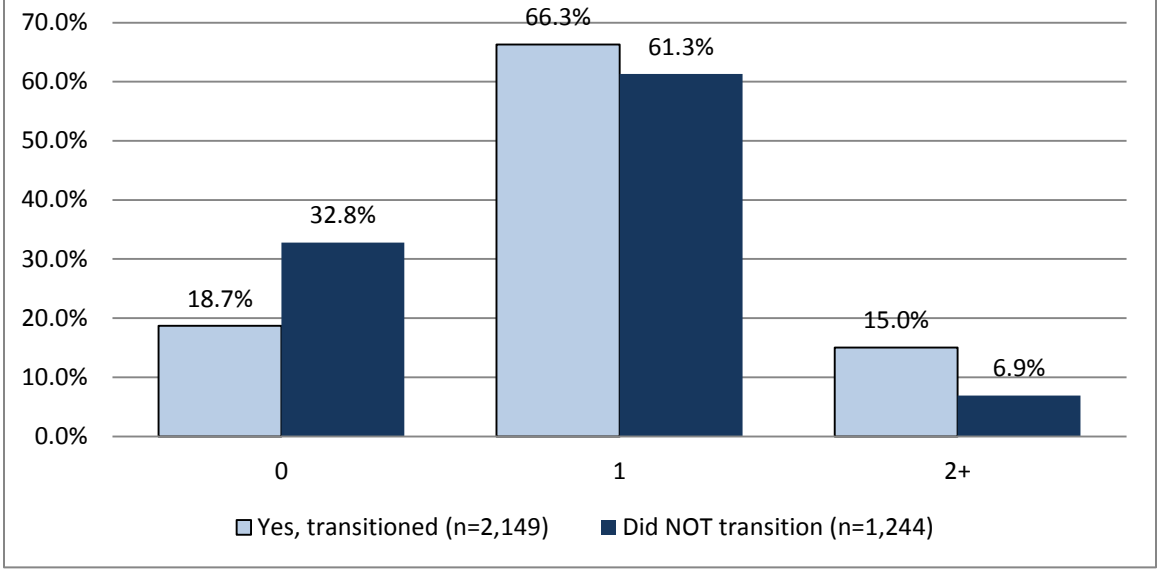


Figure 3-11 shows the number of contact types for transitioners and non-transitioners. Non-transitioners were more likely to list zero contacts and less likely to have two to three different types of contacts listed.

**Figure 3-11. Number of Contact Types for Transitioners and Non-Transitioners**




## Barriers to Transitioning

**Overview of transition challenges identified by MFP staff.** Using a standardized checklist, information was collected by MFP Transition Coordinators (TCs) and Specialized Care Managers (SCMs) on potential transition challenges for each consumer. According to a report on transition challenges produced by the UConn Health, Center on Aging,[8] the challenges are noted up until the individual either transitions, or if not transitioning, until the case closes.

There were 12 challenges included in the standardized checklist:

- Physical health (e.g., current, new or undisclosed physical health problem; or inability to manage physical disability or physical illness in community)
- Mental health or mental illness (e.g., current or history of substance/alcohol abuse with risk of relapse; current, new, or undisclosed mental health problem; or dementia or cognitive issues)
- Financial or insurance benefits (e.g., lack of or insufficient financial resources including SSI or other cash benefits)

[8] CT Money Follows the Person Transition Challenges-2015 Quarter 4. UConn Health, Center on Aging. Data through 12/31/2015.

- Consumer engagement, awareness, and skills (e.g., lack of awareness or unrealistic expectations; or lack of independent living skills)
- Services and supports (e.g., lack of PCA, home health, or other paid support staff; or lack of alcohol, substance abuse, or addiction services)
- Waiver or state plan home and community-based services (HCBS) (e.g., waiting for or denial of HCBS program or waiver services; or waiting for evaluation, application review from waiver or HCBS agency/contact)
- Housing (e.g., lacks affordable, accessible community housing; or needs housing modifications before transition)
- Legal or criminal (includes conservatorship) (e.g., missing or waiting for identity, birth certificates, etc.; or consumer criminal history)
- Facility related (e.g., facility staff or administration issues; or evaluation of consumer by facility)
- Other involved individuals (e.g., issues with spouse/partner, family or friends)
- MFP office or Transition coordinator (e.g., waiting for response/approval from MFP office; or transition plan not approved)
- Other challenges

For each of the 12 categories, more than one transition challenge could be identified per MFP participant. For example, one individual had three challenges related to physical health (e.g., medical testing issues or delays; inability to manage physical disability or physical illness in community; and current, new, or undisclosed physical health problem or illness) and another individual had four challenges related to housing (e.g., consumer will need ramp, grab bars, and PCA services for ADL; delays related to housing authority, agency, or housing coordinator; lacks affordable, accessible community housing; and needs housing modifications before transition). PRI staff considered an MFP participant to be faced with a challenge in a category if there was at least one challenge indicated.

Accuracy of data. PRI staff found a number of instances in the MFP database where "no challenges to transition" was indicated, as well as one or more challenges to transition for a single referral. This conflicting data results in an over-reporting of MFP participants with no challenges to transition. For example, the UConn Health, Center on Aging reported no challenges to transition for 648 (9 percent) of referrals with signed informed consent forms through March 31, 2016. Using corrected data, PRI found no challenges to transition for 395 (5 percent) of referrals with signed informed consent forms through June 30, 2016—the time period provided in the MFP database.

The UConn Health, Center on Aging explained that multiple people are entering information about challenges. For example, if at first, the SCM finds no challenges to transition, then he/she will check that box and save the information in the database. If at a future time challenges are identified by either the SCM or TC, then she/he will check off

those challenges and save the information in the database. Field staff has been instructed not to uncheck an item even if it no longer applies, including "no challenges to transition." PRI staff recommends:

**The Department of Social Services should either revisit data entry instructions regarding challenges to transition, or have the evaluator UConn verify that the "no challenges" status still applies**.

Transition Challenges Data. The following tables and charts show the percent of the 3,472 transitioners and 2,098 non-transitioners (missing information for 85 cases) who had at least one challenge in a particular category.

Challenges for MFP participants who transitioned vs. did not transition. There were differences in the prevalence of challenges faced by individuals who transitioned to the community via MFP demonstration and those whose cases closed without transitioning (Table 3-3). Compared with those who did not transition, those who did transition into the community were relatively less likely to have challenges related to physical health, mental health, waivers, engagement, involved, and legal—however, they were somewhat more likely to have financial, and services and supports challenges.

**Table 3-3. Challenges Faced by MFP Demonstration Participants who Transitioned vs. Did Not Transition**

| *Challenge* | *Transitioned (n=3,472)* | *Did Not Transition (n=2,098)* | *Total (N=5,570)*[a] |
|---|---|---|---|
| Physical Health** | 58% | 68% | 62% |
| Mental Health** | 38% | 51% | 43% |
| Waiver** | 30% | 43% | 35% |
| Engage** | 27% | 45% | 34% |
| Financial** | 29% | 26% | 28% |
| Involved** | 13% | 24% | 17% |
| Legal** | 16% | 19% | 17% |
| Services and Supports* | 41% | 38% | 40% |
| Facility | 14% | 12% | 13% |
| Housing | 55% | 53% | 54% |
| MFP | 20% | 20% | 20% |
| Other | 5% | 6% | 5% |

*=statistically significant P<.05

** statistically significant P<.001

[a]Missing data for 85 of the 5,655 cases who either transitioned or closed without transitioning into the community.

Source: MFP Database and PRI Staff Analysis.

As described earlier, MFP participants were categorized into the four target populations of older adults, physical disability, mental health disability, and developmental disability. For the 6,511 participants for which this information was known, Table 3-4 shows the prevalence of the challenges for each target population group. ***Physical health and/or housing were challenges for at least half the older adults, physically disabled, and developmentally disabled. Mental health and/or physical health were challenges for at least half the individuals with mental health disabilities.*** It is unclear why mental health wasn't seen as a challenge for all 100 percent--rather than just 80 percent--of the target population in the mental health category. Similarly, physical health wasn't seen as a challenge for all 100 percent—rather than 68 percent—of the target population in the physical disability category.

**Table 3-4. Prevalence of the Challenges for Each Target Population**

| ***Challenge*** | ***Target Population***[a] | | | |
|---|---|---|---|---|
| | Older Adults (n=3,118) | Physical Disability (n=2,503) | Mental Health Disability (n=590) | Developmental Disability (n=300) |
| Engage | 34% | 34% | 46% | 32% |
| Facility | 11% | 16% | 14% | 13% |
| Financial | 23% | 40% | 25% | 10% |
| Housing | 54% | 67% | 47% | 60% |
| Involved | 20% | 14% | 18% | 12% |
| Legal | 14% | 26% | 19% | 10% |
| Mental Health | 40% | 44% | 80% | 37% |
| MFP | 20% | 22% | 16% | 17% |
| Physical Health | 63% | 70% | 53% | 59% |
| Services and Supports | 40% | 49% | 28% | 30% |
| Waiver | 24% | 41% | 48% | 35% |
| Other | 4% | 5% | 6% | 8% |
| No challenges identified | 8% | 2% | 2% | 8% |

[a]Missing data for 271 participants.
Source: MFP Database and PRI Staff Analysis.
All statistically significant at p<.001, except for MFP and "other" (p<.05)

### Challenges for Earlier vs. Later MFP participants

As MFP is a demonstration project, the effort has evolved since 2008, including DSS staff addressing some challenges that became apparent over time (e.g., housing issues and the establishment of a housing coordinator position in the MFP teams). Additionally, some who were interviewed by PRI staff suggested that the "easier" cases were transitioned out earlier

(e.g., 2009 and 2010 referrals), and remaining cases have greater challenges to re-entry into the community (e.g., 2014).

Examining the information obtained from the challenges checklist, Figure 3-12 shows the three challenges that became less prevalent, and Figure 3-13 shows the six challenges that became more prevalent. No changes occurred for the challenges related to facility and mental health.

**Figure 3-12. Challenges that Became Less Prevalent from 2009/2010 to 2014**

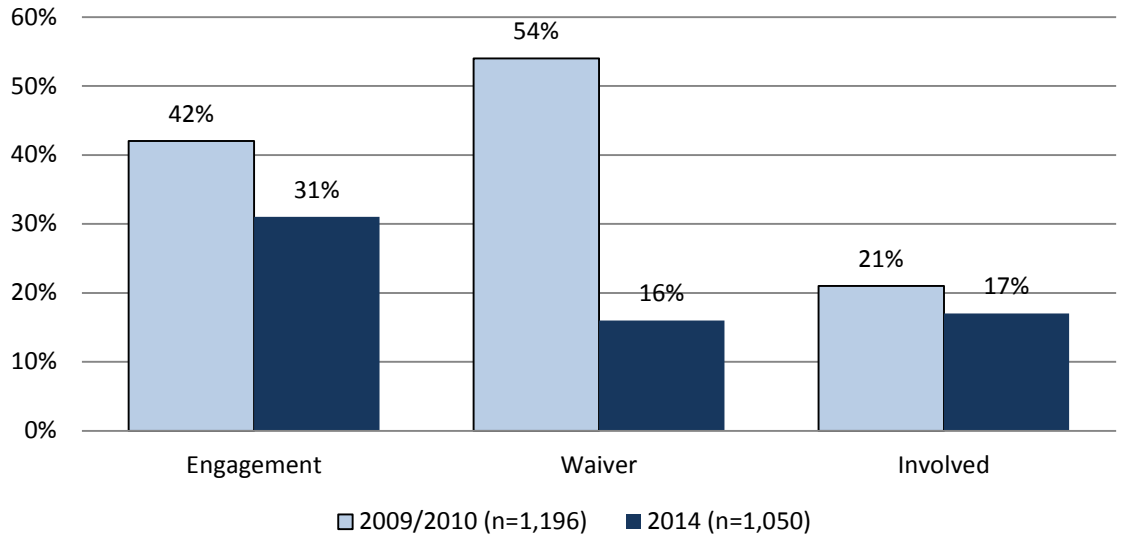
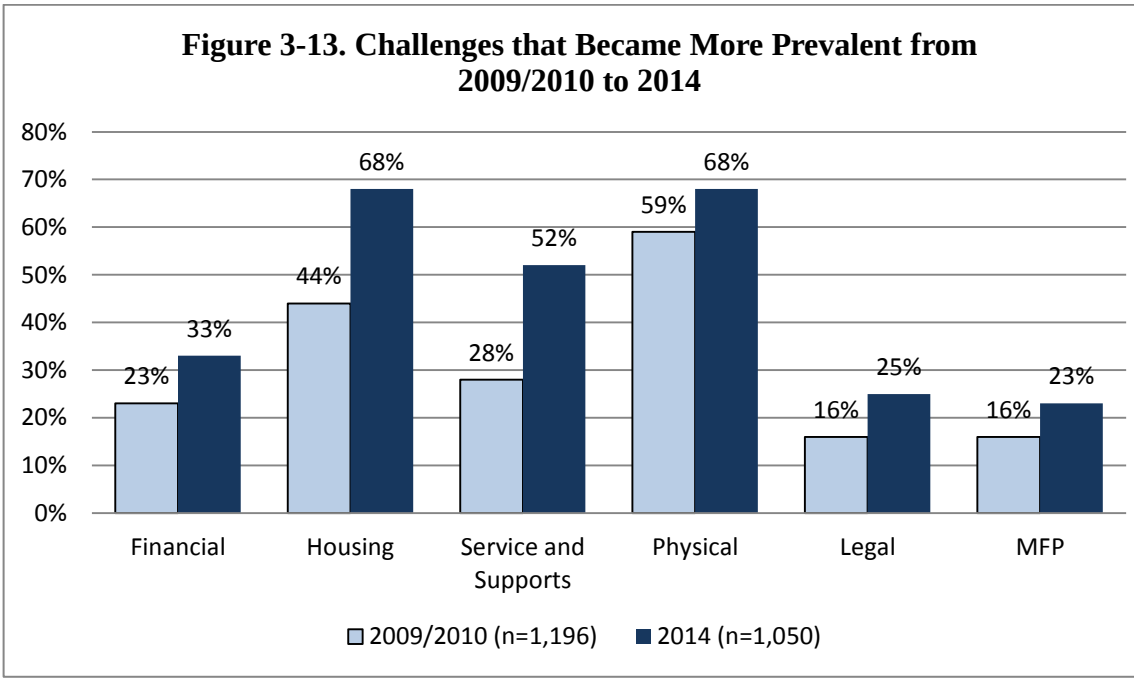



**Figure 3-13. Challenges that Became More Prevalent from 2009/2010 to 2014**



**Housing challenges.** Housing was identified as a challenge to transitioning to the community for more than half (55 percent) the individuals enrolled in the MFP demonstration program. Additional information was gathered related to housing: availability of home to go back to from nursing home; housing accessibility; and rental assistance.

Availability of home to return to from nursing home. There were just 184 individuals identified as owning their own home, often older adults. For example, 129 of the 184 (70 percent) were in the older adult target population, and almost half (85, or 46.2 percent) were at least 75 years old at time of informed consent signing.

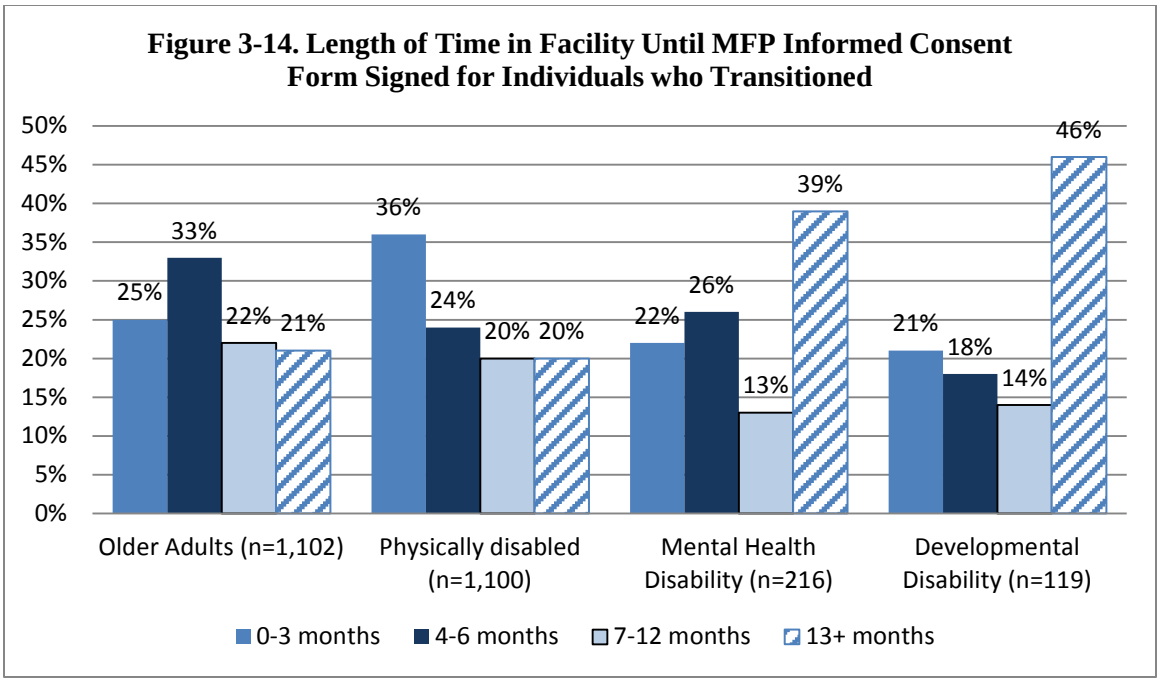
Housing accessibility. Housing accessibility did not appear to be a barrier to transitioning to the community. For example, of the 1,514 for which this information was known, 1,391 (92 percent) were reported to have accessible housing (apartment, house, etc).

RAP and other financial support for housing. Lack of rental assistance or other financial support for housing has been thought to be an obstacle to returning to the community. Some kind of financial support for housing was known for 1,368 MFP participants, most of whom transitioned (n=1,147) or are open cases that have not yet transitioned (n=171). There were 50 participants, who despite having housing assistance, did not transition into the community. Approximately three-quarters of the housing assistance was RAP assistance (74 percent), with the remainder Section 8 (2 percent), senior housing (2 percent) or other (22 percent).

In response to housing challenges, DSS has collaborated with a number of state agencies and organizations to address some issues related to housing. For example, the Innovation Accelerator Program (IAP) is an intensive, six-month technical assistance opportunity to assist Medicaid recipients in accessing and retaining stable housing. The collaboration includes the Departments of Housing, Mental Health and Addiction Services, and Developmental Services, and the Office of Policy and Management.

**Time in facility prior to MFP informed consent.** As the length of time a person lived in an institution increased, the greater likelihood there was of becoming "institutionalized" and losing interest in transitioning into the community. The median length of time a person lived in a facility until the MFP informed consent form was signed was 6 months for transitioners and 8 months for closed cases without transitioning, not statistically different.

However, Figure 3-14 shows for the 2,537 individuals for which this data was known (missing data for 963 participants), that persons in the physical disability target population had spent the shortest amount of time, and individuals in the developmental disability target population the longest amount of time in the facility before signing the informed consent form for MFP.




**Length of time in facility from informed consent until transition or closure for non-transitioners for each target population.** Figure 3-15 shows the length of time in facility until transition back into the community for the 2,583 transitioners for which this information was known (missing data for 917 participants). Once the informed consent was signed, older adults took the shortest amount of time to transition to the community, followed by those with physical disabilities. Individuals with developmental disabilities took the longest time to transition.

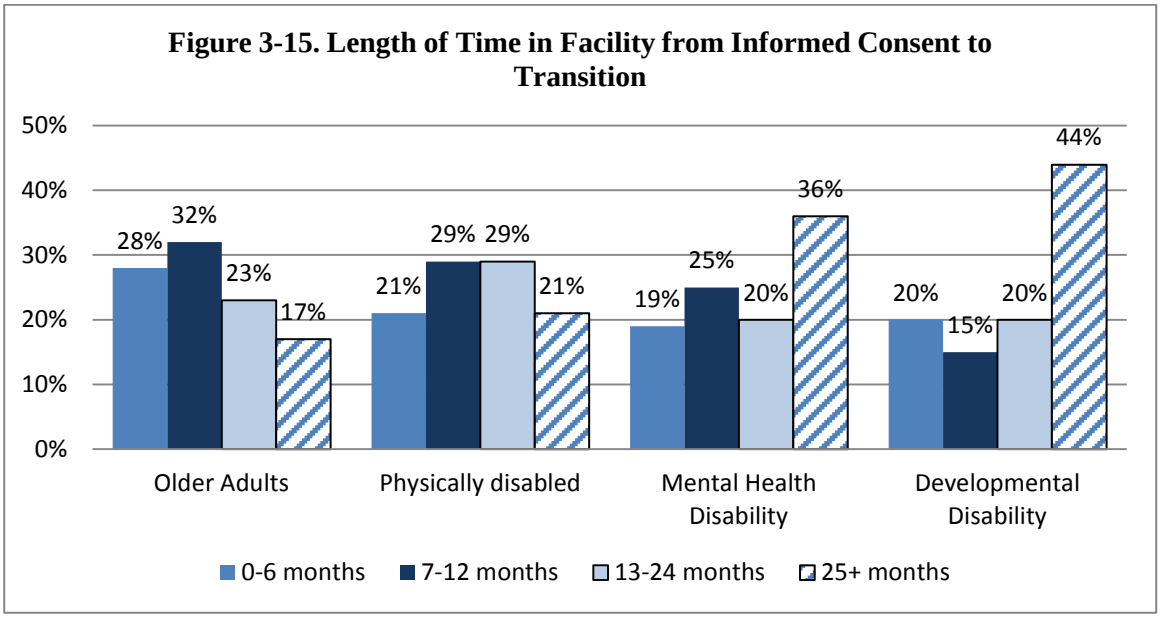
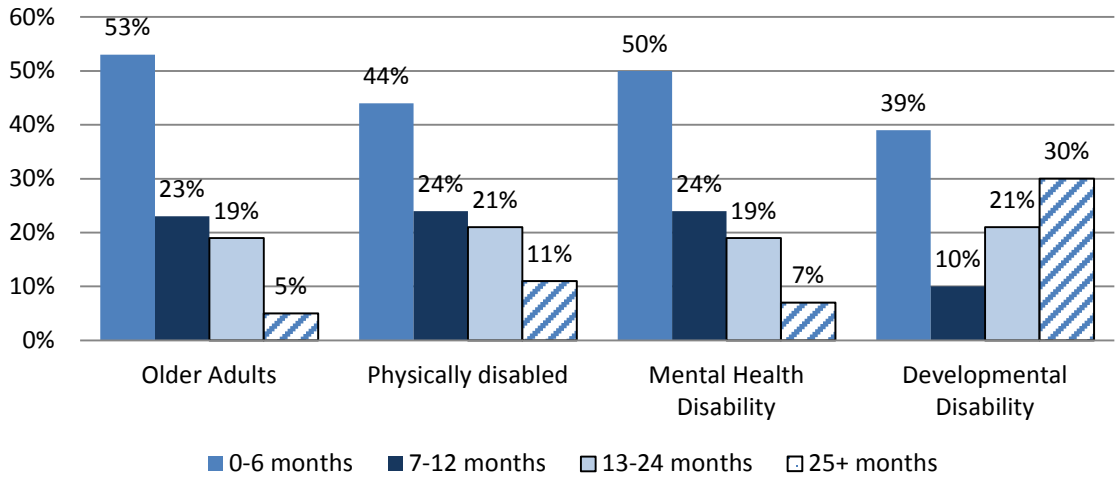


Figure 3-16 shows the length of time in facility from informed consent to closure for the 2,101 non-transitioners for which this information was known (missing data for 54 of the 2,155 non-transitioners).

- Regardless of target population:
  - cases that closed without transitioning were closed in a shorter period of time, with half closing within six months;
  - many of the transitioners with developmental disabilities required more than two years to transition (44 percent), whereas 61 percent of older adult transitioners did so within one year of signed informed consent;
- Regardless of whether they transitioned:
  - the most time was spent on individuals with developmental disabilities; and
  - the least time was spent on individuals with older adults.

**Figure 3-16. Length of Time in Facility from Informed Consent to Closure for Non-Transitioners**




**ADLs and IADLs.** Assessment of activities of daily living and instrumental activities of daily living were examined as part of the initial profile of MFP participants. Table 3-5 shows this information for the 6,719 participants—both transitioners and non-transitioners--for which it was known (missing data for 63 participants). Regardless of target population, nearly two-thirds required assistance with bathing, including nearly three in four (71 percent) older adults. The older adults and developmental disability groups had the most ADLs and the mental health disability group the least ADLs. Regarding the IADLs, the developmentally disabled and older adults had the most IADLs.

| Table 3-5. Prevalence of the ADL and IADL for each target population | | | | | |
|---|---|---|---|---|---|
| ***ADL*** | ***Target Population*** | | | | ***Total (N=6,719)[a]*** |
| | Older Adults (n=3,192) | Physical Disability (n=2,587) | Mental Health Disability (n=637) | Developmental Disability (n=303) | |
| Bathing | 71% | 60% | 33% | 64% | 62% |
| Dressing | 59% | 51% | 19% | 53% | 52% |
| Transferring | 45% | 40% | 10% | 40% | 40% |
| Eating | 14% | 13% | 2% | 31% | 13% |
| Toileting | 46% | 38% | 11% | 45% | 40% |
| Walking/Mobility | 38% | 32% | 17% | 38% | 34% |
| Average Number of ADLs | 2.7 | 2.3 | 0.9 | 2.7 | 2.4 |
| **IADL** | | | | | |
| Housework | 72% | 63% | 51% | 66% | 66% |
| Finances | 49% | 34% | 46% | 68% | 44% |
| Transportation | 65% | 54% | 47% | 69% | 59% |
| Shopping | 70% | 60% | 51% | 65% | 64% |
| Support management | 29% | 27% | 34% | 56% | 30% |
| Taking medication | 56% | 46% | 53% | 62% | 52% |
| Meal preparation | 71% | 57% | 47% | 67% | 63% |
| Use telephone | 14% | 9% | 3% | 40% | 12% |
| Other | 2% | 3% | 2% | 8% | 2% |
| Average Number of IADLs | 4.3 | 3.5 | 3.4 | 5.0 | 3.9 |
| [a]Missing data for 63 of the 6,782 MFP participants.<br>Source: MFP Database and PRI Staff Analysis.<br>All statistically significant at p<.001. | | | | | |

## Change in Nursing Home Resident Severity of Illness and Challenges

Individuals interviewed for this study anecdotally reported a perception of an increase in the acuity levels of individuals residing in nursing homes, with some believing residents with less need were transitioned out in the early stages of the program. Table 3-6 contrasts 1,035 of the 1,198 MFP participants in 2009/2010 (missing data for 163 participants) with 882 of the 1,070 MFP participants in 2014 (missing data for 188 participants), regardless of whether participant transitioned. Based on this information, evidence for increased severity in illness found there was an increase in:

- overall number of diagnoses, from 26 percent to 46 percent for six or more diagnoses;
- five of six specific diagnoses examined;
- reinstitutionalization after transition; and
- the median age of MFP participants by seven years.

| **Table 3-6. Changes in MFP Participant Health from 2009/2010 to 2014** | | |
|---|---|---|
| ***Variable*** | ***2009/2010 (n=1,035)*** | ***2014 (n=882)*** |
| *Diagnosis Present* | | |
| Cardiac or Pulmonary | 44% | 70% |
| Gastrointestinal | 20% | 27% |
| Musculoskeletal | 29% | 42% |
| Psychiatric | 42% | 51% |
| Other | 40% | 58% |
| Infections | 20% | 16% |
| | | |
| # Diagnoses | | |
| 1-2 | 40% | 21% |
| 3-5 | 34% | 33% |
| 6+ | 26% | 46% |
| Total | 100% | 100% |
| | | |
| # of Reinstitutionalizations after transitioned | | |
| 0 | 69% | 52% |
| 1 | 22% | 28% |
| 2+ | 9% | 20% |
| | | |
| Age at Informed Consent Signing | | |
| 0-17 | 0.3% | 0.7% |
| 18-64 | 63.5% | 46.5% |
| 65-74 | 17.8% | 22.2% |
| 75-84 | 11.1% | 19.3% |
| 85+ | 7.3% | 11.2% |
| Median Age | 59 | 66 |
| All statistically significant at p<.001 (infections p<.05)<br>Source: MFP Database and PRI Staff Analysis.<br>Percents may not total to 100% due to rounding. | | |

**ADLs and IADLs.** Another way to assess increase in severity of nursing home population is through prevalence of ADLs and IADLs. Except for using the telephone, the prevalence of ADLs and IADLs for participants remained unchanged or declined from 2009/2010 to 2014 (Table 3-7).

**Table 3-7. Presence of ADLs and IADLs for MFP Participants in 2009/2010 vs. 2014**

| *ADL Present* | *2009/2010 (n=1,198)* | *2014 (n=1,070)* |
|---|---|---|
| Bathing | 62% | 60% |
| Dressing | 52% | 50% |
| Transferring | 39% | 36% |
| Toileting | 38% | 38% |
| Walking/Mobility | 31% | 28% |
| Eating | 13% | 13% |
| IADL Present | | |
| Housework | 68% | 65% |
| Shopping* | 66% | 61% |
| Transportation* | 62% | 57% |
| Meal Preparation | 60% | 64% |
| Taking Medication | 51% | 53% |
| Finances | 45% | 43% |
| Support Management* | 44% | 25% |
| Use Telephone* | 9% | 13% |

*p<.01
Source: MFP database and PRI staff analysis.

Despite the increase in health diagnoses, the severity is not reflected in the ADL and IADL assessments. If DSS agrees that this finding is unexpected, then PRI staff recommends:

> **The Department of Social Services should review guidelines for completing activity of daily living and instrumental activity of daily living assessments and convey any changes to the access agencies for retraining of their staff who perform these assessments.**

**Cohort of MFP Participants who transitioned into the Community**

One way to understand the post-transition outcomes for MFP is to follow a group, or "cohort" of participants who transitioned in the same time period. To allow enough time for 365 days to elapse after transition, PRI staff selected all MFP participants who transitioned in calendar year 2014. There were 568 transitions during calendar year 20149.

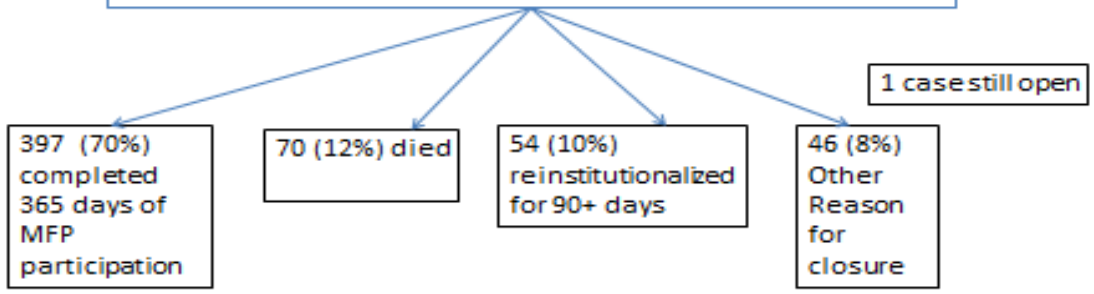
This represents the most recent transition for 535 of these transitions (94.2 percent) (There were 8 who would have an additional transition in 2015, and there were 3 who would

[9] The additional 27 non-demonstration transitions are excluded from this analysis as has consistently been the case for the analyses in this chapter.

have an additional transition in 2016). Also, there were 27 transitions in years prior to 2014 (12 had also transitioned in 2013, 8 had previously transitioned in 2012, 3 had previously transitioned in 2011, and 4 had previously transitioned in 2010).

Figure 3-17 shows the outcome for the 568 who transitioned into the community in 2014. Very few were re-institutionalized and many completed 365 days living in the community. Nearly one in five transitioned into the community with a risk agreement[10]. The outcomes for individuals with the risk agreements were not significantly different from the outcomes for individuals without risk agreements.

**Figure 3-17. Outcomes for the 568 Transitioners in Calendar Year 2014**




*109 had a risk agreement: 68% completed 365 days; 16% died; 13% reinstitutionalized; 4 closed for other reason

**Relationship of Challenges to Post-Transition Outcome**

PRI staff explored the relationship between post-transition outcomes and presence of challenges. Table 3-8 provides information on challenges for 2,791 of the 2,812 who transitioned and have a reason for closure (missing data for 21 cases). More challenges were identified for cases that remained open the full 365 days. One interpretation suggests that identifying challenges is a good thing because then they can be addressed and overcome.

Compared with challenges for transitioners vs. non-transitioners, only financial challenges were somewhat more prevalent for transitioners who remained in the community for

[10] Risk agreement forms are legal documents that individuals sign acknowledging they are assuming responsibility for certain risks by living in the community.

365 days. Housing related challenges were also more prevalent for transitioners who remained in the community for 365 days. The remaining nine challenges were not associated with whether the individual remained in the community for 365 days.

**Table 3-8. Challenges Faced by MFP Transitioners Who Remained Open for 365 Days in the Community or Closed for Another Reason**

| Challenge | Remained Open 365 Days (n=1,954) | Closed for Another Reason (n=837) | Total (N=2,791) |
|---|---|---|---|
| Financial*** | 29% | 21% | 27% |
| Housing*** | 53% | 45% | 51% |
| Other* | 7% | 5% | 6% |
| Engage | 26% | 27% | 26% |
| Facility | 13% | 11% | 12% |
| Involved | 12% | 15% | 13% |
| Legal | 16% | 14% | 15% |
| Mental Health | 34% | 36% | 35% |
| MFP | 20% | 19% | 20% |
| Physical Health | 54% | 56% | 55% |
| Services and Supports | 36% | 36% | 36% |
| Waiver | 36% | 33% | 35% |

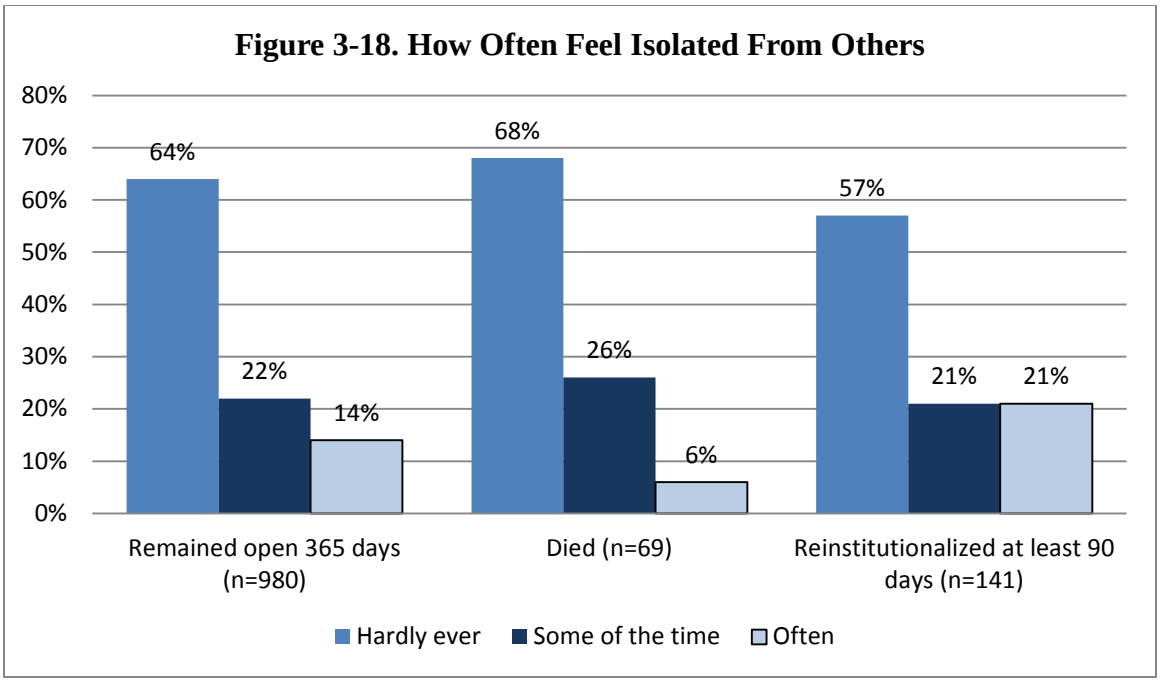
Source: MFP Database and PRI Staff Analysis.
*P<.05
***=P<.001

**Relationship of Informal Supports to Post-Transition Outcome**

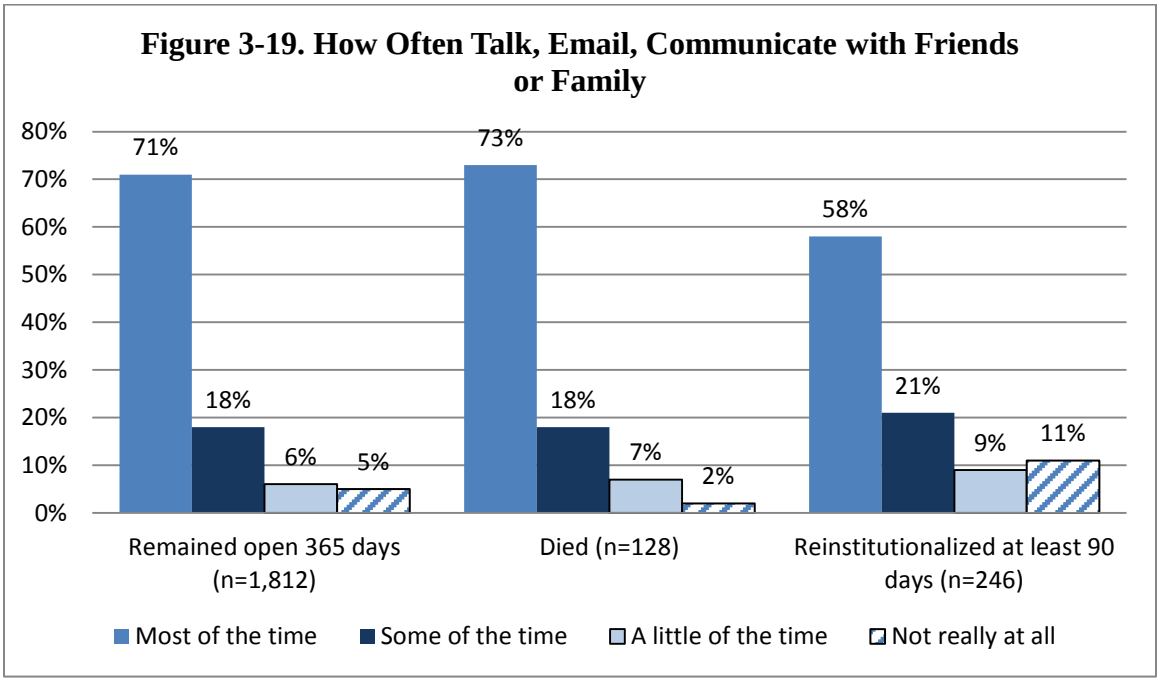
Informal supports are purportedly a key factor in remaining in the community. One source of information about informal supports comes from the Quality of Life Surveys administered periodically by UConn Health staff to MFP participants. An initial Quality of Life survey (QOL) is conducted--ideally, but not always--prior to transition by MFP staff. Additional surveys are completed by UConn at 6, 12 and 24 months post-transition. In many instances, there is missing data, particularly if a transitioner remained in the community for less than 365 days, closing for another reason, or refused to answer a question.

Among the many questions asked of transitioners at approximately six months after transition are questions about feelings of isolation, and communication with family and friends. An association was found between these two questions and transition outcome:

How often do you feel isolated from others? While there were similar responses by transitioners who had cases that remained open for 365 days before closing, or closed in less than 365 days due to death, those who were reinstitutionalized were more likely to report feeling isolated—one in five often felt isolated (Figure 3-18).

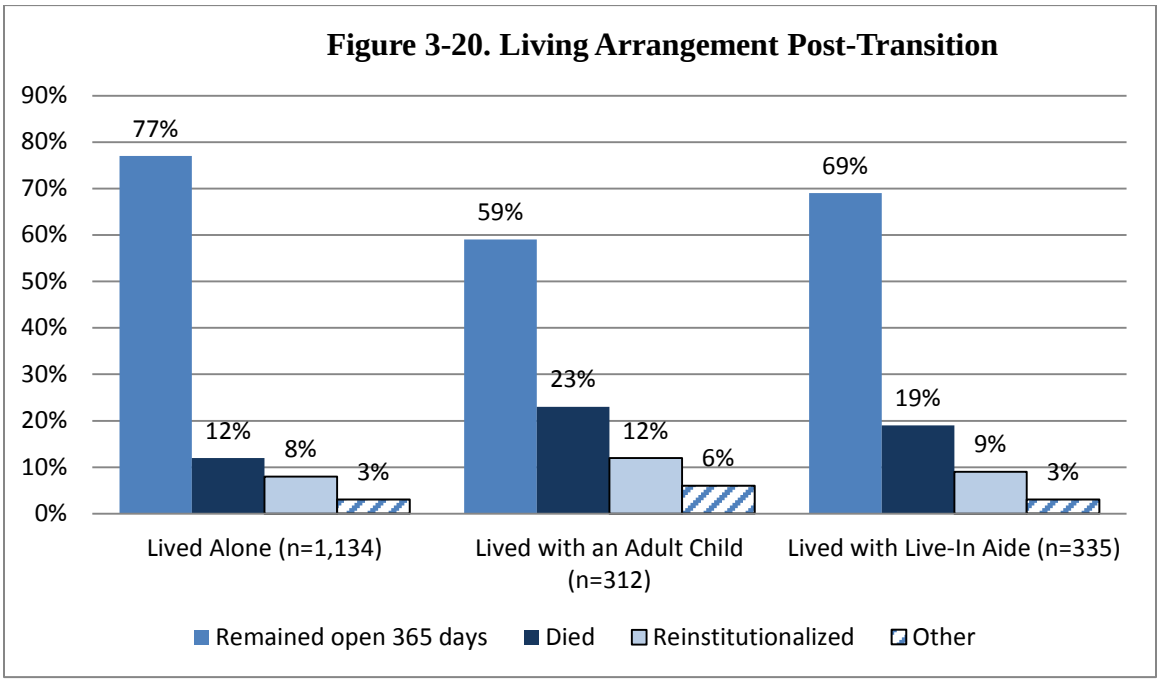



Communication with family and friends. Not including making appointments or arranging services, transitioners who ultimately remained open 365 days, or died, more frequently talked, emailed, or communicated with friends or family when they wanted to than those who became reinstitutionalized after transitioning. This pattern of isolation is consistent with the responses to the previous question (figure 3-19).



## Relationship Between Living Arrangement and Post-Transition Outcome

Another source of information about informal supports may be gathered from the variable about living arrangements, and after transition, who the consumer lives with. Figure 3-20 shows those who lived alone were somewhat more likely to remain open for 365 days, and those who died were somewhat more likely to live with an adult child or a live-in aide.




## Factors Associated with Post-Transition Outcome of Remain in Community 365 Days vs. Death

PRI staff analyzed the MFP data to determine if there were any factors associated with the outcome of remaining in the community for 365 days versus an outcome of death. Table 3-9 shows those who died within 365 days of transition were significantly older, and had longer periods of time reinstitutionalized. While those who died had slightly more diagnoses, the category of diagnoses provided more predictive information. More frequently associated with outcomes of death for transitioners, were cardiac/pulmonary and endocrine diagnoses (e.g., diabetes). Neurological and musculoskeletal diagnoses, however, were not associated with outcome.

Table 9 also shows the number of days from signed MFP consent form to transition date was shorter for those who died within the 365 days, a median difference of 2.5 weeks compared to those who remained in the community. While risk factors such as age and diagnoses cannot be impacted, PRI staff recommends:

**The Department of Social Services should examine whether more planning, preparation time, or other steps should be taken to reduce the post-transition outcome of death for individuals transitioning with the risk factors of cardiac/pulmonary and endocrine/diabetes diagnoses.**

**Table 3-9. Comparison of Post-Transition Outcomes of Remained in Community vs. Death**

| ***Median*** | ***Remained in community 365 days Post-Transition (n=1,968)*** | ***Died within 365 days Post-Transition (n=351)*** |
|---|---|---|
| Age at transition*** | 61 | 73 |
| Total Days Reinstitutionalized post-transition*** | 17 | 28 |
| Number of days from signed MFP consent form to transition date*** | 137 | 120 |
| Number of diagnoses*** | 4 | 5 |
| Percent with cardiac or pulmonary diagnosis*** | 52% | 66% |
| Percent with endocrine diagnosis*** | 34% | 47% |
| Percent with neurological diagnosis | 53% | 48% |
| Percent with musculoskeletal diagnosis | 38% | 43% |

***P<.001
Source: MFP database and PRI staff analysis.

## Risk Agreements

There were 521 MFP participants with risk agreements. Risk agreement forms are legal documents that individuals sign acknowledging they are assuming responsibility for certain risks by living in the community. A total of 397 (76 percent) with risk agreements transitioned into the community based on information provided for the period 12/4/2008 through 6/30/2016. Figure 3-21 shows the number of risk agreements and number that transitioned into the community for each year informed consents were signed. Figure 3-22 illustrates 2013 was the peak year in which participants with risk agreements transitioned into the community.

**Figure 3-21. Number With Risk Agreements and Number Transitioned by Year Informed Consent Signed**

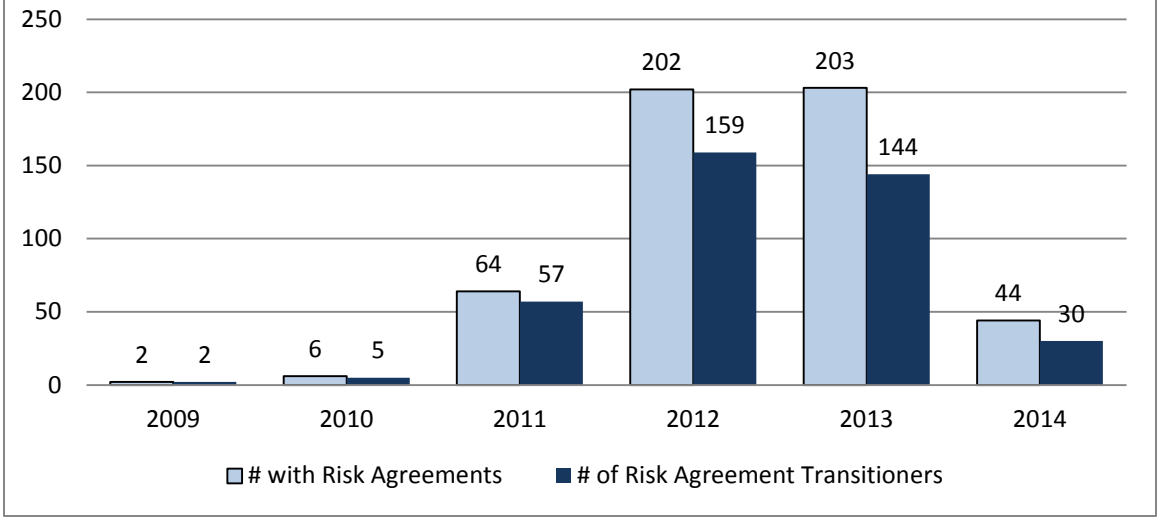
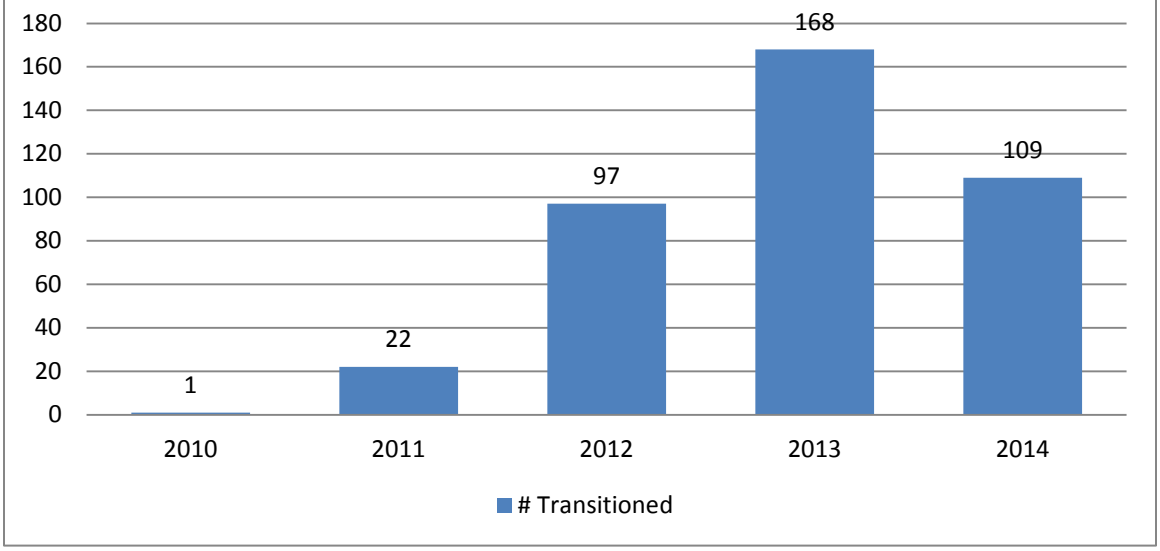



**Figure 3-22. Year in Which Those With Risk Agreements Transitioned**




Exploring this area further, Table 3-10 shows the outcomes for MFP demonstration participants who transitioned in 2013, where approximately 30 percent had risk agreements. For those with risk agreements, there is a slightly greater likelihood of being reinstitutionalized, but not as the reason for closure. There was not a statistically significant difference between the percent who remained in the community for 365 days before closure. The average number of critical incidents was slightly higher, mostly attributable to emergency critical incidents.

| Table 3-10. Cohort that transitioned in 2013 | | | |
|---|---|---|---|
| | ***Risk Agreement (n=168 )*** | ***No Risk Agreement (n=397 )*** | ***Total (N=565 )*** |
| Transitioned into Community | 168 (30%) | 397 (70%) | 565 (100%) |
| Reinstitutionalized after transition* | 96 (57%) | 186 (47%) | 282 (50%) |
| Reason for closure (NS) | | | |
| Remained in community 365 days | 109 (65%) | 281 (71%) | 390 (69%) |
| Died | 25 (15%) | 41 (10%) | 66 (12%) |
| Reinstitutionalized more than 90 days | 23 (14%) | 58 (15%) | 81 (14%) |
| Average Number of critical incidents* | 1.45 | 1.05 | 1.17 |
| Emergency Critical Incident* | 89 (53%) | 168 (42%) | 257 (46%) |
| *=statistically significant at p <.05<br>** =statistically significant at p < .01<br>*** =statistically significant at p <.001 | | | |

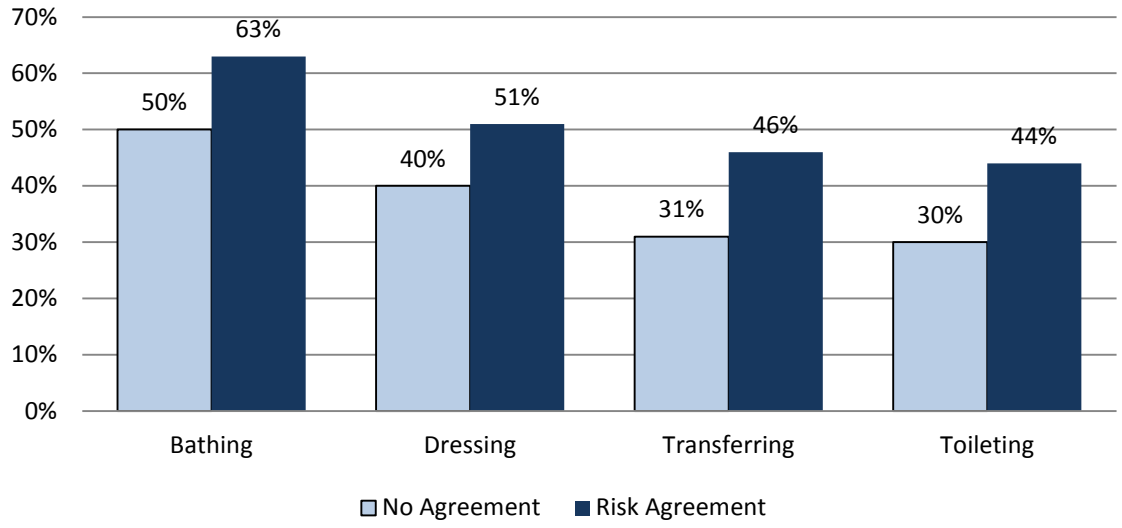
Some of the demographic characteristics and other differences between participants who transitioned with or without a risk agreement in 2013 are shown in Table 3-11. Those with risk agreements at transition were more likely to be older adults. PRI staff found similar outcomes regarding remaining in the community 365 days, and not significantly higher death rates. PRI staff recommends:

**The Department of Social Services should disseminate to access agencies and nursing home personnel the study finding of similar transition outcomes for Money Follows the Person participants with and without risk agreements. This information will address concerns about transitioning such individuals into the community and encourage the promotion of risk agreements when warranted.**

| Table 3-11. Demographic Characteristics and Other Differences for the Cohort that transitioned with and without a Risk Agreement in 2013 | | | |
|---|---|---|---|
| | ***Risk Agreement (n=168 )*** | ***No Risk Agreement (n=397 )*** | ***Total (N=565 )*** |
| Target Population | | | |
| Older Adult | 68% | 48% | 54% |
| Physical Disability | 29% | 37% | 35% |
| Mental Health | 2% | 9% | 7% |
| Developmental Disability | 1% | 7% | 5% |
| | 100% | 100% | 101% |
| Average Age at Transition | 69 | 65 | 66 |
| Due to rounding, totals may not add to 100 percent. | | | |

**Activities of daily living.** Figure 3-23 shows the four activities of daily living (ADLs) that are significantly more prevalent for MFP demonstration participants who transitioned with a risk agreement in 2013. In all instances, those who transitioned out with a risk agreement were more likely to require assistance with these ADLs. There was no difference for ADLs related to eating and walking. Regarding IADLs, there were two that were significantly more prevalent for those with risk agreements: support management ((28 percent vs. 20percent) and meal preparation (62 percent vs. 50 percent).

**Figure 3-23. Risk Agreement as Related to ADLs**




Source: MFP Database and PRI Staff Analysis.

## Geographic Differences for Older Adult Target Population

The MFP database contained information on access agency and associated geographic region for 2,902 of the 3,192 older adult target population (missing data for 290 cases). Table 3-12 shows some of the similarities and differences for the five access agencies/regions.

- NC had the greatest number of MFP participants and E the fewest—E also had a slightly lower median number of months to either transition or close a case
- NC had the least Challenges identified and NW the most
- Over half the MFP participants in the NW region had at least one services and supports related challenge
- Home ownership and living arrangements also differed by region, with NW most likely, and SW least likely, to own their home, and NW most likely to live with family
-

| Table 3-12. Similarities and Differences Across the Five Access Agency Regions | | | | | | |
|---|---|---|---|---|---|---|
| | ***South Central (Area Agency of SCC) (n=643)*** | ***Eastern (CCCI-E) (n=297)*** | ***North Central (CCCI-NC) (n=1,005)*** | ***Northwestern (CCCI-NW) (n=538)*** | ***Southwestern (Area on Aging SWC) (n=419)*** | ***Total (N=2,902)*** |
| Cumulative number of MFP participants served | 643 | 297 | 1,005 | 538 | 419 | 2,902 |
| # Challenges | 5.6 | 4.6 | **4.0** | **6.2** | 4.9 | 5.0 |
| At least one services and supports related challenge present | 37.3% | 38.5% | 34.4% | **55.9%** | 44.8% | 41.0% |
| At least one housing related challenge present | 60.7% | **49.8%** | 51.6% | 56.3% | 61.5% | 55.8% |
| Median # months from informed consent signed either transition, or close if not transitioning | 9 | **7** | 9 | 8 | 9 | 8 |
| Home owned by participant | 13.3% | 13.9% | 13.0% | 22.2% | 8.9% | 14.3% |
| Living arrangement | | | | | | |
| Live alone | 42.1% | 33.1% | 37.2% | 28.8% | 41.9% | 37.0% |
| Live with family | 36.7% | 38.7% | 36.9% | 43.8% | 31.3% | 37.5% |
| Live with live-in | 18.8% | 27.0% | 23.0% | 25.8% | 25.8% | 23.4% |
| Other | 2.4% | 1.2% | 2.9% | 1.5% | 1.0% | 2.1% |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |

# Chapter 4

## Selected Other Medicaid State Plan Long-Term Services and Supports

As noted in Chapter 1, there are other DSS LTSS services and programs available under the regular Medicaid State Plan that were examined by PRI staff. These services or programs would be available to anyone who is Medicaid-eligible and meets the functional criteria for obtaining the service. In addition, as part of the state's LTSS system, a profile of nursing homes and resident characteristics are also described. Issues with comparing cost of care between the various Medicaid waivers that promote community based care and nursing homes is also discussed.

**Home health services.** Any individual who receives Medicaid-waiver services is also eligible for services under the Medicaid state plan, including home health services if needed. These services are not limited to elderly persons, but for example, could be used by any individual who experienced a hospital stay and needed additional at-home services upon discharge.

Medicaid reimburses medically necessary services provided by licensed home health agencies that are delivered in the home. In order to receive services, they must be ordered by a physician or nurse practitioner. The order is sent to a home health agency that will do an assessment of the client and work with the physician or nurse practitioner to complete an appropriate plan of care. Covered services include:

- nursing;
- home health aides;
- physical, occupational, and speech therapy; and
- nursing for high risk pregnancies .

*Service limitations*. DSS covers the services of a home health aide only when the aide is assisting with activities of daily living (ADL). ADLs are bathing, dressing, toileting, transferring, and feeding. The department will not pay for an aide to do housework or other chores, although an aide who is in the home to help with an ADL (for example, feeding) may perform some minor housework at the same time (for example, tidying up the kitchen).

In addition, prior authorization is needed from DSS for:

- all home health aide services in excess of 14 hours per week;
- all nursing in excess of 2 visits per week;
- all nursing in excess of 2 hours per day; and
- other services as described in department regulation.

The request for prior authorization must come from the home health agency that will be providing the service.

DSS does not track the number of individuals who receive home health services on a long-term basis to determine if DSS is providing LTSS through home health care only and in lieu of another LTSS program, or if these services are being leveraged along with other LTSS so that people are able to avoid nursing home or other institutional care. In its annual CHCP report, the department does try to provide a rough estimate of use of home health services by CHCP Medicaid-eligible recipients and attributes 22 percent of total home health costs to CHCP clients in its last report. However, there are many other individuals receiving LTSS in other LTSS programs. The Office of Policy and Management, through the Long-Term Care Planning Committee, also estimates the cost of home health services for all Medicaid programs, including those offered by DDS and DMHAS, at 60 percent of total home health expenditures.

Given that home health services under Medicaid is are another source of LTSS being provided by DSS, PRI staff believes attributing the dollar amount of these services is important because it does impact the cost of services delivered in the community. **Therefore, PRI staff recommends:**

> **The Department of Social Services and the Office of Policy and Management should reach a consensus on the percent of home health service expenditures that be attributed to Medicaid state plan, Medicaid waiver, and state-funded recipients.**

**Community First Choice**. A relatively new Medicaid state plan program, introduced in July 2015, is called Community First Choice (CFC). It is an optional state plan service allowed under Section 1915 (k) of the Social Security Act and was established under the Affordable Care Act of 2010. This option provides a six percent increase in federal matching payments to states for service expenditures related to this option, in addition to the 50 percent FMAP. It is a reflection of the federal government's shift to providing individuals on Medicaid with a community option that is not part of a Medicaid waiver. Total expenditures in FFY 15, including federal Medicaid reimbursement of 50 percent, were $2,857,754.

Medicaid beneficiaries who require nursing facility or other institutional level of care are eligible for CFC. Beneficiaries of this service must self-direct their community-based services using individual budgets, with the support of a fiscal intermediary. Self-direction means the person or someone they appoint makes the decisions regarding services. Program recipients have control over what services they want in their homes, and the responsibility for managing those services. Individual that are enrolled in CFC can hire from pools of qualified staff or they can hire certain family members and friends.

Services available under CFC include personal care assistants and other self-direction supports. These services can include—but are not limited to—help in self-hire personal care attendant; home delivered meals; emergency response system; support and planning coach; and assistive technology. Staff can be used to go out to community activities, and doctors' appointments, and provide help with errands. Family members, with certain exclusions, can provide services to the beneficiary.

As of August 31, 2016, DSS reported:

- 2,197 applications were received;
- 1,003 applicants were referred to an Access Agency;
- 383 service plans were submitted; and
- 313 service plans were approved.

If individuals who are currently on a waiver, but are also Medicaid eligible under the state plan and use self-directed Personal Care Assistants (PCA) on their waiver, they will automatically become CFC participants for the covered services.

**Long-Term Services and Supports Provided by Nursing Homes in Connecticut**

The Office of Policy and Management maintains a Nursing Home Registry and provides information annually on the characteristics of nursing homes and the residents. According to the OPM registry, as of September 30, 2015, there were 230 nursing homes in the state with a private pay cost of $407 per day in a semi-private bed, or slightly more than $148,500 annually.

There were a total of 27,414 beds, a decline of eight percent since September 30, 2004. There were 23,842 residents, 499 fewer than on the same date in 2014 and 3,954 fewer than in 2004. Occupancy rates also continued to gradually decline. The average nursing facility occupancy rate statewide was 87 percent. In addition:

- the majority of residents were white (83 percent);
- female (67 percent);
- without a spouse (80 percent); and
- 65 years old or older (87 percent);
    - Of which 48 percent were age 85 or older.

In the past, OPM collected information on admissions, readmissions and discharges, as well as the number of ADL limitations nursing home residents had. Based on information from September 30, 1999, 73 percent of nursing home admissions and readmissions were from a general hospital, while the majority of discharges were either to home or a general hospital (35 percent and 36 percent respectively). PRI staff believes this type of information is useful to gauge progress on the rebalancing ratio and therefore **PRI staff recommends:**

> **The Nursing Home Registry should capture information on admissions, readmissions, and discharges, as well as a summary of the number of activities of daily living limitations by resident. In addition, the Nursing Home Registry should report on individuals separately, counting those are considered short-term and are receiving rehabilitation versus those in the long-term care portion of a nursing home.**

*Significantly lower Medicaid rate paid to nursing homes*. The Medicaid rate paid to nursing homes is significantly lower than the private pay rate. As of July 1, 2015, the statewide average Medicaid rate was $233 per day or $85,045 for all non-specialized facilities compared to the private pay rate of $400 for a semi-private room or slightly more than $148,500 annually (as of September 30, 2014). The state receives 50 percent reimbursement for Medicaid residents. Based on 2013 data, the payor mix for clients residing in nursing homes was:

- 70.4% Medicaid;
- 13.3% Medicare;
- 10.9% private pay; and
- 5.4% other (e.g., veterans/N.Y. Medicaid).

**Issues Regarding Comparing Costs of Community versus Nursing Home Care**

There are several differences between receiving LTSS in a home and community-based setting versus in a nursing home or other institutional setting. They are:

- nursing homes are residential facilities, and assume total care of the individuals who are admitted;
- the per diem fee includes include room and board, as well as most other services;
- Medicaid services received under community-based programs are specifically prohibited from including room and board;
- the services received are billed and reimbursed as a single bundled payment rather than on an individual fee-for-service basis; and
- nursing homes must be licensed and certified by the state, according to federal standards and must undergo periodic survey to maintain their certification and license to operate.

Based on testimony provided to the PRI committee at its September 21, 2016 hearing, services provided under the Medicaid program to residents in nursing home facilities on a twenty-four hour/seven days a week basis include:[1]

- skilled nursing care
- routine nursing care
- personal care
- physical therapy
- occupational therapy
- speech pathology
- clinical care supervised by a licensed medical director
- three meals a day
- housekeeping and laundry services
- recreational activities;

[1] Connecticut Association of Health Care Facilities, Inc. September 21, 2016 PRI public hearing, submitted written testimony.

- social services by licensed personnel
- durable medical equipment
- housing
- supplies and specialized medical equipment
- incontinence care
- 24-hour monitoring
- 24-hour RN care available
- All housing related costs.

Actual net state Medicaid expenditure per day is $74, once federal matching funds, applied income, and a nursing home provider tax are deducted for a net annual state cost of $27,010.

Nany of the Medicaid waivers allow the plans of care to exceed 100 percent of institutional care and therefore, for some individuals, the costs of community care is likely much higher than institutional care. Table 4-1 shows the maximum annual cost of care under Medicaid waiver or CHCP programs ranges from $17,488 to $798,240. For institutional care, the average annual cost was $69,816 for nursing home care, $177,379 for ICF/IID, and $406,008 for chronic disease hospital care that for some individuals, it can be more expensive to receive LTSS in the community compared to nursing home/institutional care. More detail on each waiver and the state-funded CHCP maximum annual cost limits for an individual's plan of care are shown in Appendix D.

**Table 4-1. Cost Maximums on Community Care Plans under Medicaid Waivers and State-Funded CHCP.**

| ***Source of LTSS*** | ***Type of Institution*** | | | ***Maximum Annual Cost Limit in 2016*** |
|---|---|---|---|---|
| | **NH** | **CD** | **ICF/IID, Other** | |
| CHCPE Category 1 | √ | | | $17,448 |
| CHCPE Category 2 | √ | | | $34,908 |
| **Nursing Home** | | | | **$69,816**[1] |
| Katie Beckett | √ | √ | √ | $69,816-$399,124 |
| CHCPE Category 3 | √ | | | $80,280 |
| PCA | √ | | | $80,280 |
| Mental Health (WISE) | √ | | | $87,270 |
| ABI II | √ | √ | √ | $104,724-$598,687 |
| ABI I | √ | √ | √ | $139,632-$798,240 |
| **ICF/IID** | | | | **$177,379** |
| DDS Comprehensive | | | √ | $252,363 |
| **Chronic Disease Hospital** | | | | **$406,008** |

[1]This average is lower than the $85,048 Medicaid reimbursement rate cited above because the average applied income is deducted from the full Medicaid reimbursement rate. (i.e, the amount the applicant must "contribute to the cost of care,").

Source: Department of Social Services

While it is likely that, on average, the costs of care under the waivers is much lower than the cost maximums, this information should be available. The state has already committed to a philosophy of promoting community care for individuals[2], however, the true costs of those services have never been compared. Therefore, to fully understand the cost to Connecticut of LTSS in the community versus institutions, **PRI staff recommends:**

> **The Department of Social Services should conduct an analysis of the distribution of individuals by costs, grouped into cost ranges, for each Medicaid waiver program. A summary of the department's findings should be provided to the legislative committees of cognizance, including the Joint Committee on Appropriations, subcommittee on Human Services.**

[2] C.G.S. Section 17b-337(a) states: that Connecticut's long-term care "policy and plan shall provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting."

# Chapter 5

## Programs to Prevent and Divert Institutionalization

While the Connecticut Department of Social Services maintains information about state residents who are Medicaid recipients and enrolled in Medicaid-funded programs such as Money Follows the Person, there is little known about *all* Connecticut residents aged 65 and older—including non-Medicaid recipients. A January 2016 report by the Connecticut Long-Term Care Planning Committee noted that while long-term services and supports have traditionally been associated with nursing homes and other institutional care, the vast majority of such care is provided by informal and formal caregivers in home and community-based settings.[1]

According to the 2010 Decennial Census, there were 3,574,097 individuals living in Connecticut, and 506,559 of them (14.2 percent) were age 65 and older. One source of more detailed information about the general older adult population comes from the U.S. Census American Community Survey (ACS).

This chapter provides a profile of Connecticut's older adult population. It also discusses prevention programs that are aimed at keeping individuals out of nursing homes and in the community. Both DSS and the State Department on Aging fund a variety of these programs, which are highlighted later in the chapter.

**About the American Community Survey.** The ACS is a survey of a sample of residents in all 50 states, the District of Columbia, and Puerto Rico. The ACS annually samples residents living in both households and group quarters, such as nursing homes. About half the responses to the survey are obtained by mail, with the remainder from telephone and face-to-face interviews.

Results are available by state and age category for one-, three-, and five-year time periods. Analyses in this chapter are based on five-year population estimates collected from Connecticut residents aged 65 or older during 2010-2014.[2] Of the total sample of 32,174 residents age 65 or older, 30,070 (93.5 percent) lived in households in the community,[3] and the remainder--2,104 (6.5 percent)--lived in institutions, almost always nursing homes for this age group.

**Demographic differences.** This ACS data was used to ascertain any demographic differences among the 65+ year old population in Connecticut (Table 5-1). *Compared with*

[1] Connecticut Long-Term Care Planning Committee, "Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut." A Report to the General Assembly, January 2016.

[2] According to the U.S. Census Bureau, in comparison to one year ACS estimates, five-year ACS estimates are considered the most reliable, largest samples, including data for all state geographic areas, regardless of population size. http://www.census.gov/programs-surveys/acs/guidance/estimates.html

[3] An additional 308 residents, who lived in non-institutional facilities such as emergency shelters and group homes, were excluded from these analyses.

*residents living in the community, nursing home residents are more likely to be an average of nine years older and female, and more than five times as likely to be a Medicaid recipient.*

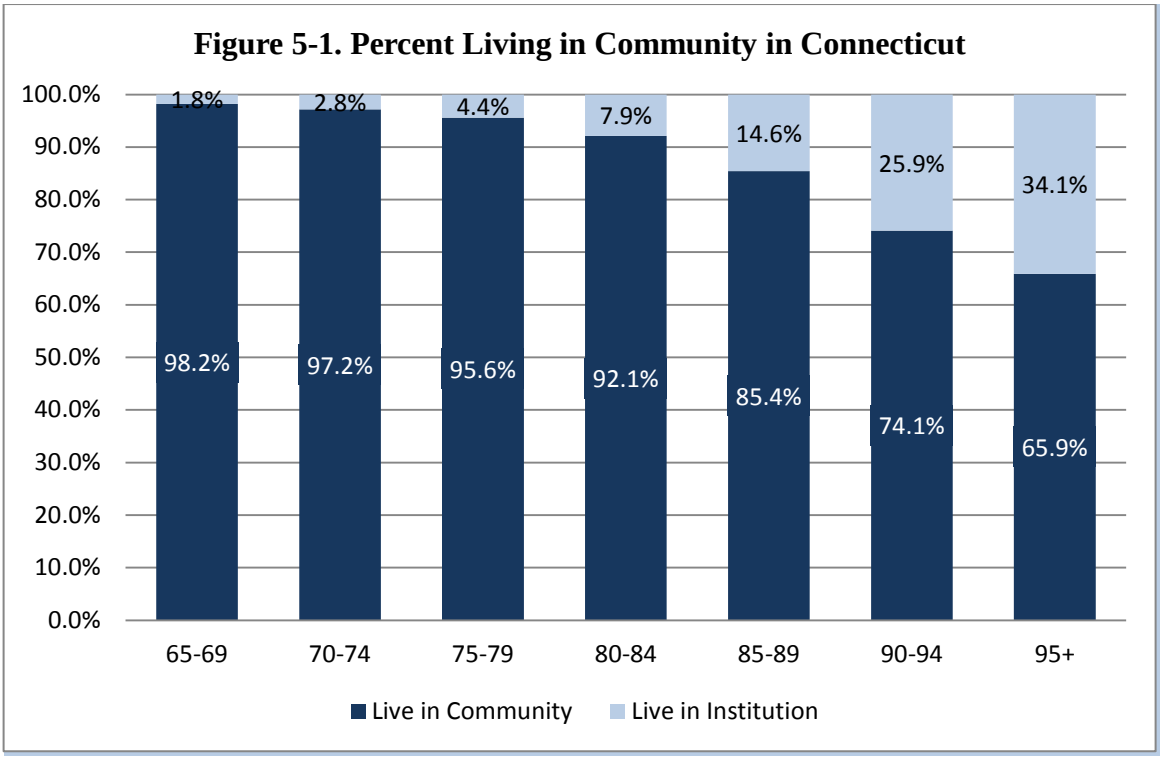
**Table 5-1. Demographics**

| ***Compared to community residents, are nursing home residents more likely to be:*** | | ***Live in Household (n=30,070; 93.5%)[a]*** | ***Live in Nursing Home (n=2,104; 6.5%)*** |
|---|---|---|---|
| Relatively older?<br>YES | Average Age | 75 | 84 |
| Female?<br>YES | Percent Female | 56% | 72% |
| White, non-Hispanic?<br>NO | Percent White, Non-Hispanic | 89% | 85.4% |
| Medicaid recipients?<br>YES | Percent receiving Medicaid | 12.5% | 67.7% |

[a] Total of 30,070 excludes 308 living in noninstitutional facilities such as emergency shelter and group homes; grand total: 32,174

***While an increasing percent live in nursing homes as they age from 65 to 95+, even at 95+ years of age, two-thirds are still living in the community*** (Figure 5-1)**.**

**Figure 5-1. Percent Living in Community in Connecticut**



**Disability differences.** As noted in the U.S. Census Bureau report, "65+ in the United States,"[4] key indicators of health status are disabilities, defined by the Institute of Medicine of the National Academy of Sciences as an umbrella term for impairments.[5] The ACA data was used to answer questions about disability differences. Compared with community residents—and regardless of Medicaid status, nursing home residents are more likely to have disabilities (Table 5-2), especially related to independent living, ambulatory, self-care, and cognitive areas. For 65+ year olds living in Connecticut, ***nursing home residents have an average of four areas of difficulty compared with one area of difficulty for persons living in the community.***

**Table 5-2. Disabilities**

| *Area of Difficulty:* | *Defined by U.S. Census Bureau as:* | *Present for community based person (n=30,070)* | *Present for institutional based person (n=2,104)* |
|---|---|---|---|
| Independent living | Having difficulty doing errands alone, such as visiting a doctor's office or shopping due to a physical, mental, or emotional problem. | 13% | 90% |
| Ambulatory | Having serious difficulty walking or climbing stairs. | 18% | 89% |
| Self-care | Having difficulty bathing or dressing. | 7% | 86% |
| Cognitive | Having difficulty remembering, concentrating, or making decisions due to a physical, mental, or emotional problem. | 7% | 66% |
| Hearing | Deaf or having serious difficulty hearing. | 13% | 29% |
| Vision | Blind or having serious difficulty seeing, even when wearing glasses. | 5% | 20% |
| At least one disability | | 31% | 98% |
| Average number of areas of difficulty | | 1 | 4 |

Source: American Community Survey 2010-2014 and PRI staff analysis.

**Difficulties related to activities of daily living (ADL) and instrumental activities of daily living (IADL).** Disabilities are divided into activities of daily living (ADL) and instrumental activities of daily living (IADL). ADL limitations encompass difficulty or inability

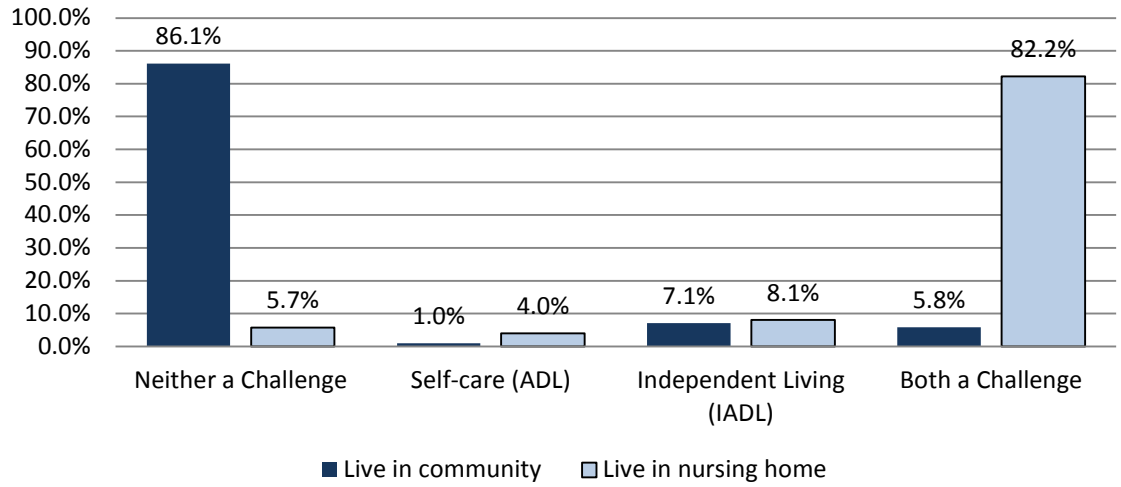
[4] 65+ in the United States: 2010. Special Studies, Current Population Reports, Loraine A. West, Samantha Cole, Daniel Goodkind, and Wan He. Issued June 2014, United States Census Bureau.

[5] Disabilities are defined as impairments (i.e., a problem in body function or structure); activity limitations (i.e., difficulties people face executing activities); and participation restrictions (i.e., problems that an individual may experience in involvement in life situations) (Institute of Medicine, 2007).

to perform, for a health reason, such basic tasks of everyday life as bathing, dressing, eating, toileting, and mobility issues. IADL limitations include difficulty or inability to perform, for a health reason, more complex tasks such as using a telephone, housework, meal preparation, shopping, and managing money.

The American Community Survey assesses difficulties related to ADLs using a measure called "self-care." Self-care asks questions about difficulty dressing and bathing[6]. The ACS measures difficulties related to IADLs using a measure called "independent living." Independent living asks questions about difficulty doing errands alone, such as visiting a doctor's office, or shopping[7]. Figure 5-2 contrasts the prevalence of ADL and IADL related disabilities for Connecticut residents living in nursing homes vs. community settings.

**Figure 5-2. Prevalence of Independent Living and Self-Care Challenges for 65+ Year Old Connecticut Residents in Institutional and Community Based Settings**




***While there are significantly fewer community residents with ADL and IADL challenges compared with nursing home residents, approximately 14 percent of older residents currently residing in the community have ADL and/or IADL challenges.***

Based on the Census population estimate reported earlier of 506,559 Connecticut residents aged 65 or older, and 93.5 percent in this age group living in the community (473,633), this 14 percent equates to approximately 66,308 individuals currently living in Connecticut communities experiencing ADL and/or IADL challenges, approximately 87.5 percent of whom (according to Table 5-1) are not Medicaid recipients, and therefore ineligible for Medicaid waiver or state plan services. The following describes some low-cost/no-cost strategies for maintaining these individuals in the community.

[6] Katz Activities of Daily Living (ADL) Scale.
[7] Lawton Instrumental Activities of Daily Living (IADL) Scale.

## Programs That Prevent Nursing Home Admissions

The state and federal governments fund a variety of prevention programs aimed at diverting individuals away from nursing homes and allowing older adults and persons with disabilities to remain in the community. These programs include respite and adult day care, fall prevention, chronic self-disease education, and congregate housing. There is also another strategy, called telemonitoring, that Connecticut's Medicaid program has not yet adopted but is aimed at preventing illnesses by monitoring certain individuals with diseases that are high-risk for hospitalization. A description of these prevention programs is provided in this chapter.

## Respite for Caregivers

Respite is defined by Merriam-Webster Dictionary as "an interval of rest or relief." It is a service that supports and maintains the primary caregiving relationship by providing temporary relief for those caring for an elderly spouse, parent, or relative, or a loved one who has a disability and needs assistance with activities of daily living (ADLs)and instrumental activities of daily living (IADLs). Respite can be provided in many settings, including in a person's home or at a center or over-night facility, including nursing homes. Respite may be offered on a daily or short-term basis, including overnight stays.

Many individuals provide caregiving to relatives or close friends who have chronic, disabling, or serious health problems and would need institutional care in the caregivers' absence. Caregivers help loved ones with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (such as bathing, dressing, toileting, preparing meals, administering medications, driving to doctor visits, and paying bills), so their loved ones can remain at home.[8]

An AARP report estimated there were about 40 million family caregivers in the U.S. that provided 37 billion hours of care to parents, spouses, partners, and older loved ones in 2013. The report estimates the cost of that care at $470 billion nationwide, and $5.9 billion for Connecticut caregivers.

While the report suggests several strategies that would better support caregivers and would alleviate the stress of providing care to loved ones, each comes with a cost. These include:

- tax credits for individuals who provide care or for remodeling projects (such as ramps) that would allow individuals to remain in the community rather than becoming institutionalized;
- flexibility in the workplace for individuals who provide care;
- respite care, including adult day care, where caregivers get personal time alone;

[8] Caregiver' is defined as an adult age 18 and older providing care to a parent, spouse, or other adult loved one with their daily activities such as assistance in bathing or dressing, preparing meals, and/or managing their finances.

- home care services to shift the sole responsibility of caregiving to paid workers; and
- improved caregiver training to boost confidence in their ability to provide appropriate and safe care.

Although each strategy does have associated costs, the intent is to prevent an individual's placement in a nursing home which can be even more costly. These strategies are also aimed at providing relief to a caregiver so institutionalization of a loved one can be prevented or is postponed.

**Respite in Connecticut**

The responsibility of being a primary caregiver can be emotionally and physically stressful. Table 5-3 estimates the number of informal, unpaid Connecticut caregivers, the hours of care provided, and the per-hour cost of that care ($13.87 an hour).

| **Table 5-3. Estimated Informal Supports Provided by Family Caregivers in CT** | |
|---|---|
| Number of Family Caregivers | 459,000 |
| Number of Hours in Unpaid Family Care Annually | 427,000 |
| Economic Value per Hour | $13.87 |
| Total Economic Value | $5.9 billion |
| Source: Susan C. Reinhard, Lynn Friss Feinberg, Rita Choula, and Ari Houser. Valuing the Invaluable: 2015 Update, AARP Public Policy Institute, Table B1. | |

As noted above, respite can either be provided in-home or in an out-of-home setting. One service that offers respite on a frequent basis to caregivers in Connecticut is Adult Day Care (ADC). Typically, ADCs provide day-time supervision for needy individuals in a group environment. Individuals served may include persons with disabilities, are diagnosed with various types of dementia, or are physically frail. Respite programs provide assistance to individuals with ADL limitations and often would qualify for a nursing home level of care in the absence of such programs.

**Types of publicly-funded respite in Connecticut.** Respite is provided to caregivers in Connecticut through a variety of programs that are funded, depending on program eligibility, through DSS, SDA, and DDS. This study focused only on those respite programs funded by DSS and SDA. Both agencies use a combination of funds – DSS uses Medicaid and state funds for its programs, and SDA uses federal Older Americans Act (OAA) funds and state funds.

Both respite services and adult day care are considered cost-effective services that often prevent individuals from having to enter a nursing home by relieving the sometimes overwhelming stress experienced by a person's caregiver. In Connecticut, the average

reimbursement for publicly-funded adult day care providers is about $70 per day compared to the average Medicaid reimbursement rate to nursing homes of $233 per day.[9]

By paying for adult day care, Medicaid helps many families care for loved ones at home. In doing so, this reduces the number of nursing home admissions which are paid for (or will eventually be paid for) by Medicaid. So paying for adult day care is, in fact, a cost saving measure for most Medicaid programs as the cost of adult day care is very minor when compared to the cost of full-time nursing home care.

**Department of Social Services Respite Programs**

Respite services are available for clients of several DSS programs. PRI staff focused on two programs that serve the most clients:

- The Connecticut Home Care Program:
- Money Follows the Person

**Connecticut Home Care Program.** Both in-home and out-of-home respite services are available through CHCP and are part of a client's care plan. Adult day health is a separate line-item and is accounted for separately from respite services. For adult day health care, the Medicaid waiver requires the service to be provided four or more hours per day on a regularly-scheduled basis for one or more days per week. It must be delivered in a non-institutional, community-based setting and include both a health and social component.

Under the program, in-home respite is limited to 720 hours per year and can be provided by homemakers, companions, or home health aides, as well as others. Out-of-home respite, provided by a licensed facility such as a nursing home, is limited to 30-days per year (excludes adult day health).

Table 5-4 shows the total number of people served and expenditures for FY 14. It should be noted that a very small number of individuals receive respite services and for those that do, it likely is less than 30 days per year given the daily cost is about $70. A possible reason for this is caregiver relief may be provided under another type of service within an individual's plan of care. For example, a caregiver may be able to do other activities if a homemaker or another provider is with the individual needing care.

**Table 5-4. CHCP Service: Respite (SFY 2014)**

| *CHCP Category* | *Annual Recipients* | *Total Annual Expenditures* | *Annual Expenditure per Recipient* |
|---|---|---|---|
| State Funded | 17 | $29,537 | $1,737 |
| Medicaid Waiver | 23 | $75,453 | $3,281 |
| State Plan Medicaid | 0 | 0 | 0 |

Source: Department of Social Services

[9] This is a gross rate and is before federal matching funds, an individuals applied income, and a nursing home provider tax are deducted.

Table 5-5 shows the number of CHCP recipients that received adult day health services, along with expenditure data. In total, there were 2,134 adult day care recipients - about 19 percent were state-funded recipients; 76 percent were Medicaid waiver recipients; and 4 percent were Medicaid State Plan recipients.

| **Table 5-5 CHCP Service: Adult Day Health Care (SFY 2014)** | | | |
|---|---|---|---|
| ***CHCP Category*** | ***Annual Recipients*** | ***Total Annual Expenditures*** | ***Annual Expenditure per Recipient*** |
| State Funded | 415 | $2,414,776 | $5,819 |
| Medicaid Waiver | 1626 | $12,927,638 | $7,951 |
| Medicaid State Plan | 93 | $485,286 | $5,218 |
| Source: Department of Social Services | | | |

**Caregiver Homes**. This program is a service that is available under CHCPE Medicaid and the PCA waiver. The program, called Adult Family Living, began in March 2014 and is operated by the company, Caregiver Homes of Connecticut. The program helps frail elderly individuals to remain living in private homes rather than moving into assisted living communities or nursing homes. The program provides financial assistance and support for family members or friends that act as primary in-home caregivers.

Under AFL, an elderly individual moves into the home of a family member or friend or vice- versa. The family member or friend is designated as the primary caregiver and receive training, oversight and support from an intermediary agency certified by the state. The caregiver receives compensation for providing the elderly individual with assistance completing their ADLs and IADLs. AFL has four levels of compensation for the care providers and payment ranges from $43 per day to $108 per day. There are four separate levels of service provided and it is based on the number of ADL or IADL limitations the caregiver is providing care for. As of October 2016, the service levels of individuals served under AFL were:

- Level 1 – 8 consumers;
- Level 2 – 36 consumers;
- Level 3 – 107 consumers; and
- Level 4 – 395 consumers.

It is important to note, the family caregiver works through an intermediary agency and that agency takes a percentage of the daily rate estimated at between 20 percent to 40 percent.

Referrals come directly from the state's Access Agencies. Once a referral is received, a Caregiver Home RN care manager provides an onsite assessment. It includes a "no touch" interview and assessment. The provider works with the access agency care manager to get services approved. The caregiver receives basic training as well as education tailored towards the particular situation. The goal is to keep the person safe at their home. Typically there is a

monthly visit as well as telephonic check-in on a weekly basis. In interviews with PRI staff, Caregiver Homes emphasized respite is also an important service component for a caregiver.

The company providing this service also operates in six other states (including two New England states – Massachusetts and Rhode Island) and serves more than 7,000 consumers. The service is an in-home structured family caregiving model that allows caregivers to care for an elder or family member with complex medical conditions or disabilities at home. It offers guidance, financial assistance, and overall support at every step along the way to both the caregiver and the client. To date, the company has served over 400 consumers in Connecticut. The model is intended to be a high-quality alternative to those full-time models of care that would normally include staying in a facility or bringing in home providers to assist the caregiver.

The service is available for individuals who are eligible for either CHCPE or PCA, need help with ADLs and have a caregiver that is at least 18 years of age (spouses and legally liable persons are excluded from the service). Company representatives provided PRI staff with a snapshot of caregiver services. Since its inception, the program has served 546 consumers and there were 387 active consumers as of October 2016. Based on the total number of individuals served since March 2014:

- the average age is 80.4 years old;
- 80.4 percent are female;
- 20 percent have a medically-diagnosed dementia;
- the average length of stay is 14 months;
- reasons for discharge (159 consumers since 2014):
  - 50 percent due to death
  - 14 percent due to long-term care placement;
  - 14 percent transitioned to other services;
  - 17 percent due to eligibility; and
  - 11 percent were for other reasons.

According to the company, the typical caregiver in the Adult Family Living program is a 51 year old female who speaks English. Over 94 percent of caregivers are family members (most often a daughter or son) or otherwise known to the consumer.

The program has grown from its inception in SFY 14 from seven to 634 recipients in SFY 16, an indication that it is a popular model for family caregivers. Total costs for the program have also increased, from $23,499 in SFY 14 to almost $12.6 million in SFY 16 (an average cost of almost $20,000 annually per recipient).

**Money Follows the Person Demonstration Grant.** Respite is also available under MFP. Reimbursement is allowed for respite provided in the home, in adult day centers, or in other settings. Provision of this service can make it easier for families who wish to see their loved one leave an institution and return home.

**Programs Administered by the State Department of Aging.**

The State Department of Aging provides funding to the five Area Agencies on Aging (AAA) for two respite programs. They are The Connecticut Statewide Respite Program, and the National Family Caregiver Support Program. Each program is described separately below.

**Connecticut Statewide Respite Program.** The Connecticut Statewide Respite Program (informally known as Alzheimer's Respite) is a joint partnership between the Alzheimer's Association Connecticut Chapter, the Area Agencies on Aging, and SDA. The program offers relief to caregivers by providing them with information, assisting in the development of an appropriate care plan, and funding services for individuals who are diagnosed with Alzheimer's Disease or related dementia. There are no age limits but income and asset limits apply.

Clients can receive care directly from service provider agencies or caregivers may self-direct care by opting to hire someone of their choice to provide care. There is a maximum of $7,500 in services available per year to each applicant and a maximum of 30 days annually of out of home respite care services (excluding adult day care).

The program offers short-term respite care for persons with Alzheimer's disease and related dementias. The program provides in-home assessments, the development of care plans, and the purchase of necessary services to give caregivers a break from the physical and emotional stresses associated with care giving. Services may include but are not limited to: cognitive training, companions, homemakers, adult day care, home health aides, skilled nursing or short-term inpatient care in a nursing facility, residential care home, or a stay in an assisted living community. Individuals may also choose their own caregiver to provide services (the spouse, Conservator, and relatives of the Conservator are excluded). Families may receive daytime or overnight respite services.

In order to be eligible for the program, an individual must have Alzheimer's Disease or a related dementia. Income and asset limits apply - applicants income cannot exceed $44,591 a year, have liquid assets of $118,549 or less, and cannot be enrolled in the Connecticut Home Care Program for Elders. In addition, a co-payment of 20 percent of the cost of services is required unless waived by the Agency on Aging Care Manager due to financial hardship.

SDA provided detailed information to PRI staff for each AAA about the statewide respite program, shown in Table 5-6. For SFY 16, statewide, there was a total of $1,973,368 allocated for the program and 794 clients served, with an annual cost of $2,485 per client. Although the cost of this program is modest, it provides support to individuals remaining in the community and their caregivers and helps avoid more costly institutionalization. State funds were reduced by more than $50,000 to a funding level of $30,000 in SFY 16.

**Table 5-6. Statewide Connecticut Respite Program**

| ***Funding Source*** | ***FY 14*** | ***FY 15*** | ***FY 16*** |
|---|---|---|---|
| State Funding | $83,575 | $83,575 | $30,000 |
| AAA Matching Funds | $2,096,095 | $2,096,095 | $1,943,368 |
| Co-pay | n/a | n/a | n/a |
| **Total** | $2,179,670 | $2,179,670 | $1,973,368 |

Source: State Department on Aging

Table 5-7 shows the number of individuals served for each of the last three SFYs, as well as the number of caregivers that received respite through the program. The reason that the number of recipients is higher than the number of caregivers is because some caregivers have multiple care recipients. The number of recipients served and the caregivers receiving respite dropped each year over the three year period examined.

| **Table 5-7. Recipients of the Connecticut Statewide Respite Program** | | |
|---|---|---|
| | **Year** | **# of Recipients** |
| Recipients | SFY 16 | 794 |
| | SFY 15 | 828 |
| | SFY 14 | 861 |
| Caregivers Receiving Respite | SFY 16 | 776 |
| | SFY 15 | 806 |
| | SFY 14 | 821 |
| Source: State Department on Aging | | |

The State Department on Aging also provided PRI staff with demographic and ADL information for individuals that received respite services and were 65 years of age or older. For SFY 2016:

- 501 recipients (63 percent) were female;
- 424 recipients (53 percent) needed assistance with 3 or more ADLS;
- 73 recipients (9 percent) lived in poverty;
- 152 recipients (19 percent) lived alone; and
- 508 recipients (64 percent) were age 80 or older, of which 355 recipients (45 percent) were 85 years old or older.

The AAAs survey caregivers who receive respite services under the Statewide Connecticut Respite Program. The survey asks three questions about whether the program was helpful in maintaining the recipient at home as well as reducing caregiver stress. SDA provided three years of responses to PRI staff, which are shown in Table 5-8. Based on the responses provided, clearly caregivers find the respite program valuable in both helping a loved one remain in the community, as well as relieving the stress caregivers experience in providing care.

| **Table 5-8. Percent of Caregivers Responding Yes to Survey Questions (SFY 14 – SFY 16)** | | | |
|---|---|---|---|
| ***Question*** | ***SFY 14*** | ***SFY 15*** | ***SFY 16*** |
| Were the program services beneficial in assisting the client in remaining at home during some portion of the program year? | 87% | 79% | 91% |
| Was the care recipient able to remain home for the entire program year? | 92% | 92% | 96% |
| Was the program effective in improving the caregiver and client's quality of life and reducing caregiver stress? | 90% | 81% | 89% |
| Source: State Department on Aging | | | |

**The National Family Caregiver Support Program.** The other respite program is funded by Title IIIE of the Federal Older Americans Act and is operated in partnership with the CT State Department on Aging and the five Area Agencies on Aging. The program provides information to caregivers about available resources; connects caregivers to available services (i.e. support groups); and also can offer individual counseling to assist caregivers in making decisions and solving problems relating to their caregiving roles, in addition to providing respite services.

A cost-sharing fee is requested for respite and any supplemental services provided. The contribution is based on the cost of services and the care recipient's monthly income. Annual funding per recipient is limited to $700.

In order to be eligible for the program, individuals must be:

- adult family members or other informal caregivers age 18 and older providing care to individuals 60 years of age and older;
- adult family members or other informal caregivers age 18 and older providing care to individuals of any age with Alzheimer's disease and related disorders;
- grandparents and other relatives (not parents) 55 years of age and older providing care to children under the age of 18; or
- grandparents and other relatives (not parents) 55 years of age and older providing care to adults age 18-59 with disabilities.

The five AAAs received a total of $2,221,460 in FFY 15. Table 5-9 shows funding and individuals served over the last two years by the program. There is no state allocation of funds for this program. In addition, no information was available on the number of individuals served and whether there was a wait list for services.

**Table 5-9. The National Family Caregiver Support Program**

| ***Source of Funding*** | ***FFY 14*** | ***FFY 15*** |
|---|---|---|
| Title III(E) Funding | $1,728,760 | $1,717,627 |
| State Funding | n/a | n/a |
| AAA Matching Funds | $606,841 | $613,744 |
| Family Contribution (different from co-pay) | $2,721 | $2,468 |
| **Total** | $2,335,601 | $2,333,839 |
| Source: State Department on Aging | | |

SDA provided detailed information to PRI staff for each AAA about recipients of the National Family Caregiver Support Program. There were a total of 319 recipients in FFY 15:

- 202 recipients (63 percent) were female;
- 122 recipients (38 percent) needed assistance with three or more ADLs, with almost 40 percent of this group age 85 or older;

- 31 recipients had income below poverty; and
- 13 recipients lived alone.

**Other Diversion Programs**

**Care Management/Transition in Hospital Settings.** The Department of Social Services, Home and Community Based Services Unit, recognized the importance of hospital care transition support as a function of the care management role within the CHCP and added this service into the CHCP waiver. This service was discussed with Connecticut Community Care, Inc. (CCCI) one of the three Access Agencies in the state that conducts assessments, develops care plans and provides ongoing care management support for for CHCP recipients. CCCI is currently co-located in three hospitals. CCCI developed Memorandum of Understandings (MOU) with - Charlotte Hungerford Hospital, Danbury Hospital and Saint Francis Hospital. The MOU allows CCCI to co-locate staff in those hospitals in order to intervene with hospitalized CHCP recipients by examining care plans with the intent to avoid discharge to a nursing home if possible. CCCI staff are co-located part-time in the three hospitals.

CCCI collects data on the number of encounters they have with CHCP recipients and the recipients discharge location (i.e., home or nursing home). They do not track service plan of care increases that would, if needed, increase levels of services so that upon discharge, the recipient could return to the community rather than enter a nursing home. In sharing this data with PRI staff, CCCI emphasized that one should not attribute cause and effect absolutely but that the organization was able to substantiate in at least one hospital (Danbury) that:

- the number of days in the hospital decreased;
- discharge to home versus nursing home increased;
- if discharged to nursing home the likelihood of returning home increased; and
- 30-day hospital readmissions had decreased.

CCCI indicated that they were able to track these measures because of a collaborative analysis with Danbury Hospital using shared data. CCCI provided PRI staff with performance data on the interventions at Danbury Hospital (shown in Table 5-10). The data measured performance based on seven goals.

The Danbury Hospital Care Transition Pilot served 487 (unduplicated) CHCP-CCCI active or pending clients and 108 (unduplicated) non-CHCP-CCCI Danbury and area residents who were admitted to Danbury Hospital or treated in the Emergency Department between January 1 and December 31, 2015. Among the individuals served, there were 923 admissions or ED treatment episodes at Danbury Hospital. Full care transition services, which includes both a hospital reassessment visit and community follow-up by a CCCI care manager, were provided to 337 unduplicated CCCI clients who had a total of 555 admissions to Danbury Hospital.

| Table 5-10. Connecticut Community Care, Inc. Pilot Program of Care Management in Hospitals – Measures of Performance | |
|---|---|
| ***Goal*** | ***Result*** |
| Continue to demonstrate a reduced 30-day readmission rate to Danbury Hospital among the population being served. | Danbury Hospital's calculation of 30-day readmission rates factor out individuals admitted or re-admitted to the hospital from a rehabilitation facility. Danbury Hospital reported a 30-day readmission rate from January to December 2015 of 14.5% for persons age 65 and older. The 30-day readmission rate for CHCP-CCCI clients who received care transition services under the Danbury Hospital pilot from January to December 2015, factoring out clients admitted or re-admitted from a rehabilitation facility was substantially lower at 11%. Readmission data is unavailable at this time for at risk non-CHCP-CCCI clients. |
| Continue to demonstrate a reduction in discharges to skilled nursing facilities and an increase in discharges back to the community. | Danbury Hospital reported a rate of discharge from January to December 2015 for persons age 65 and older from hospital to home of 53.8% (55.2% including home with hospice) and a rate of discharge from hospital to nursing facility of 37.9%, including discharge to sub-acute rehabilitation, Medicaid nursing facility, inpatient rehabilitation facility, and long-term care facility.<br><br>CHCP-CCCI clients who received the full Danbury Hospital care transition service from January to December 2015 continued to have a higher rate of discharge to home of 57.7% (58.9% including home with hospice) than the Danbury Hospital comparison group. The rate of discharge to SNF was also lower, but not significantly so, at 37.5%. Discharge data is unavailable at this time for at risk non-CHCP-CCCI clients. |
| Continue to provide a growing number of referrals to the CHCP and other community resources and programs. | From January to December 2015, 108 non-CHCP-CCCI Danbury and area residents (63 Danbury residents and 45 residents of surrounding towns) received health education and information about community resources, including CHCP, private-pay in-home services and providers, Medicare skilled in-home services, DSS entitlements including Medicaid, SNAP, and Medicare Savings Programs, Danbury or other town Senior Centers' services including transportation, housing resources, caregiver respite grants, and elder law resources for asset and long-term care planning.<br><br>Of the 108 participants, 72 were referred to the DSS - CHCP in order to access additional home and community based services. |

| Table 5-10 Continued. Connecticut Community Care, Inc. Pilot Program of Care Management in Hospitals – Measures of Performance | |
|---|---|
| ***Goal*** | ***Result*** |
| Continue to improve consumer understanding of their discharge instructions and red flag symptoms regarding their chronic conditions | All persons served by the Danbury Hospital care transition service (and families or supporters when appropriate) received education related to chronic disease self- and family-management, including the identification and recognition of red flag symptoms, symptom prevention, and appropriate intervention at symptom onset.<br><br>Between January and December 2015, 337 CHCP-CCCI clients received the complete care transition pilot services including a review of discharge instructions, medication reconciliation, and facilitation of medical appointments. |
| Continue to help ensure coordination between Danbury Hospital and community providers (joint goal with the Hospital) | Feedback from patients, families, and Danbury Hospital staff confirm goal achievement. One of the most important elements of the care transition intervention is the enhanced communication between the CCCI care transition care manager, hospital case management staff, and the CCCI community care manager who sets up and implements the enhanced care plan, helps ensure follow up medical appointments are kept, including arranging supports such as transportation when needed, and collaborates with the visiting nurse and other community providers. |
| Continue to improve medication reconciliation for patients in their transitions back to the community (joint goal with Danbury Hospital) | Following discharge, the CCCI community care manager makes a 24-hour contact that includes checking to see if the individual has their new medications, has been in contact with the skilled nursing agency, and is aware of their medical appointments. The CCCI community care manager also makes an in-home visit, usually within 72 hours of the transition to home, in which the care manager facilitates medication reconciliation, re-education regarding red flags or warning signs of worsening condition, review of follow-up medical appointments including transportation, and review of hospital discharge instructions. |
| Continue to demonstrate measurable cost savings through lowered length of hospital stays. | The Kaiser Family Foundation indicates the Hospital Adjusted Expenses per Inpatient Day (2014) in Connecticut is $2,419.<br><br>Danbury Hospital reported the average length of stay from January to December 2015 for persons age 65 and older as 8.14 days. The average length of stay from January to December 2015 for CCCI clients who received the full care transition service during their admission was 6.26 days. This calculates to a cost savings of $4547.72 per admission. It appears that the care transition service is correlated with shorter length of stay, thereby resulting in a cost-savings. |
| Source of Data: Connecticut Community Care, Inc. | |

Based on the data provided by CCCI, PRI staff believes this is an effective way to divert individuals from nursing home admissions upon discharge from a hospital. PRI staff believes that recipients that are hospitalized and enrolled in other Medicaid Waiver programs could also benefit from the care transition process currently being provided by CCCI for CHCPE clients. **Therefore, PRI staff recommends:**

**The Department of Social Services should continue to support the care transition role under the Connecticut Home Care Program. The initiative should be phased in to include other Medicaid waiver recipients (Personal Care Assistant, Acquired Brain Injury) and recipients under the Money Follows the Person Demonstration Grant who are hospitalized based on a schedule determined by the Department of Social Services. The responsibilities and role of the Access Agencies should specify criteria for measuring the effectiveness of the intervention in diverting individuals from nursing home admission and should track the increase in services needed to divert such admission.**

**The Department of Social Services, along with the Access Agencies and hospitals interested in participating in the program, should form a working group to develop a standardized memorandum of understanding that would allow the Access Agencies to enter into data and client record sharing agreements with the hospitals and health networks for the purposes of:**

- **identifying participants of waivers at the point of admission;**
- **accessing the waiver recipients electronic health records;**
- **reviewing and documenting care transition activities;**
- **accessing the discharge summary to better reinforce discharge plans; and**
- **accessing home care agency skilled nursing records, nursing home records and physician records if in an Accountable Care Organization.**

**The Department shall develop and adopt a shared risk tool for hospitals and the Access Agency to use for Medicaid clients to identify those at high risk for readmission/nursing home placement. By targeting Medicaid recipients, hospitalized individuals could be screened for transition services promptly when hospitalized as a nursing home diversion strategy.**

**Congregate Housing Services Program.** The Congregate Housing Services Program (CHSP) provides meals and services to frail elderly individuals and to persons with disabilities. The purpose of the program is to prevent unnecessary institutionalization; improve management's capacity to assess service needs of its residents; coordinate the provision of supportive services to meet the needs of eligible residents; and ensure long-term provision of such services. The State Department on Aging receives funds from the U.S. Department of Housing and Urban Development (HUD) to provide CHSP supportive services, with a 40 percent match from the state SDA, which gives them OAA Title III funds and the two Area Agencies on Aging contribute 10 percent towards total funding.

There are no income or asset limits for CHSP services. However, an individual must have at least three ADL limitations, which are defined differently than the definitions under the DSS CHCPE program. There is a copay of 25 percent, but a client cannot be charged more than 20 percent of the clients adjusted gross income for the services provided under the program.

CHSP services are available in selected housing communities in Eastern and Western Connecticut. Senior Resources (in the Eastern region) and the Western Connecticut Area Agency on Aging operate the CHSP in their respective regions. A Resident Services Coordinator (RSC) provides site-to-site monitoring of the CHSP program and ensures that appropriate service plans are developed and implemented for eligible residents.

To qualify for services under the program, an individual must live in one of the designated senior housing sites and need assistance in at least three of the daily living activities, which would also qualify an individual for nursing home care. Participants must pay 10 percent of the cost of support services.

In each region, the care plan for a potential recipient is brought before a Professional Assessment Committee (PAC) for approval of services as well as any recommended follow-up on a particular individual. Subsequent six-month re-assessments are completed with each active client and again presented to the PAC. The costs of services are shared by the participant, a Housing and Urban Development (HUD)/Rural Development grant, Senior Resources, and the State Department on Aging.

Senior Resources has eight HUD-funded housing sites with a total of approximately 200 units. The housing is for individuals who are elderly or disabled. The units are full and there is a 1.5 – 2 year waiting list for a unit. Residents have to put 20 percent of their income toward services and their housing/rent. The following housing sites are serviced through the grant:

- Gan-Aden 1 & 2, Willimantic;
- Eastwind Village, Plainfield;
- Cedar View Village, Plainfield;
- Moosup Manor, Moosup;
- Salem Village, Brooklyn;
- Westfield Village, Danielson; and
- Little River Acres, Putnam.

For those individuals who qualify and agree to services under CHSP, a care plan is developed by the resident service coordinator along with the individual. In FFY 15, there were 119 residents receiving case management from a Resident Services Coordinator from Senior Resources. The total cost of case management was $84,789 annually, which is about 20 percent of the $425,515 total program expenditures. Supportive services include:

- meals;
- housekeeping;
- home health aides;

- foot care;
- companion;
- transportation; and
- personal emergency response systems.

All services budgeted for through the program are contracted out with local providers in the community.

In the Western Area Agency on Aging, the following housing sites are available:

- Chestnut Grove, Winsted;
- George B. Lewis I, Naugatuck;
- George B. Lewis II, Naugatuck;
- Grace Meadows, Southbury;
- Nunnawauk Meadows, Newtown;
- Torringford West, Torrington; and
- Greenwood Garden, Winsted.

Information on CHSP recipients is reported to SDA by the Western AAA and Senior Resources in the Eastern Region. As shown in Table 5-11 and Table 5-12, there were a total of 310 CHSP recipients in both regions. Of these, only 67 left CHSP during FFY 15, with 78 percent of individuals able to continue to live in CHSP and only 20 recipients (6 percent) permanently relocated to a nursing home.

In addition to the information shown in the tables, almost all recipients of CHSP were age 62 or older and the vast majority of them were female. Also, it is important to remember that in order to be eligible for the program an individual must have at least 3 ADL limitations, which are defined more broadly than the definitions that determine ADL limitations under the DSS CHCPE program.

**Table 5-11. Age of CHSP Recipients in FFY 15**

| ***Age*** | ***Senior Resources (N=119)*** | ***Western AAA (N=191)*** |
|---|---|---|
| Age Range | 48 years old – 98 years old | 58 years old – 101 years old |
| Average Age: Elderly | 81.7 | 77 years old |
| Number Elderly | 110 recipients | 187 recipients |
| Average Age: Disabled | 53.7 years old | 57 years old |
| Number Disabled | 9 recipients | 4 recipients |
| Source: State Department on Aging | | |

| Table 5-12. Reasons for People Leaving CHSP During FFY 15 | | |
|---|---|---|
| ***Reason*** | ***Senior Resources (N=27)*** | ***Western AAA (N=40)*** |
| Death | 5 | 12 |
| Permanently Relocated to a Nursing Home | 6 | 14 |
| Relocated to Family | 2 | 3 |
| Out of CHSP but Remained in Housing | 4 | 6 |
| Moved Out of Senior Housing Site | 6 | n/a |
| Received Services from CHCP | 4 | n/a |
| Other | n/a | 5 |
| Source: State Department on Aging | | |

**Chronic Disease Self-Management**

One cause of entry into a nursing home is difficulty self-managing a chronic disease, such as arthritis, high blood pressure, anxiety, depression, heart and lung disease, asthma, or any chronic pain. The State Department on Aging[10] administers funding to area agencies on aging to offer a chronic disease self-management program, called "Live Well."[11] Live Well is a national evidence-based program developed by Stanford University.[12] This six-week program is offered once a week for 2.5 hours at senior centers, libraries, hospitals, housing units, and other locations in the community.

As described on the State Department on Aging website, the purpose of this evidence-based program is to help older adults and caregivers:

- find better ways of dealing with pain and fatigue;
- discover easy exercises to help improve or maintain strength and energy;
- learn the appropriate use of medications;
- improve nutrition;
- talk effectively with family, friends and health professionals;
- understand new treatment choices;
- feel better about life; and
- increase confidence in ability to manage health.

The workshops are facilitated by two specially trained leaders, at least one of whom is a non-health care professional with a chronic disease. The setting provides a peer group for chronic disease sufferers and caregivers. Participants break into groups and learn how to have goals, learn the symptoms and management of their diseases, and make action plans. In general, there is a lot of commonality regardless of the particular chronic disease, with the exception of diabetes, and there is a separate program for individuals with diabetes.

[10] Funded through Older American Act Title IIIE.
[11] The program is also offered in Spanish, and called "Tomando Control de su Salud."
[12] Developed in the 1990s by the School of Medicine at Stanford University during a five year research grant to design and evaluate a community-based self-management program that assists people with chronic illness.

From January 1, 2009 through to November 22, 2016, there were a total of 4,124 Connecticut participants (74 percent completion rate) across 386 workshops held in both English and Spanish, and for general chronic diseases and diabetes self-management. The program was funded by $47,500 in state funds and $93,299 in Federal Title IIID waiver funds. The combined $140,799 breaks out to a cost of $34.14 for each of the 4,124 participants.

While no outcome data was collected, Connecticut is adhering to an evidence-based model, and would be expected to have outcomes similar to those found in other states and through national studies. The following are summaries of two studies on this evidence-based model.

| | |
|---|---|
| Study Participants | 952 California patients 40+ years old with physician-confirmed diagnosis of heart disease, lung disease, stroke, or arthritis |
| Outcome | Treatment subjects, compared with control subjects had:<br>• More minutes of exercise<br>• Fewer hospitalizations<br>• Fewer days in the hospital |
| Cost-Savings | Assuming a cost of $1,000 per day of hospitalization, and individual program cost of $70 per participant, there was an average savings of $750 per participant compared with the control group (not everyone was hospitalized) |
| Potential Reduction in Nursing Home Stays | Since hospital stays and length of hospitalization are associated with an increased likelihood of nursing home entry, a reduction in hospitalizations and length of hospital stays may be associated with a decrease in nursing home entries |
| Evidence Suggesting That a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A Randomized Trial. Kate R. Lorig, David S. Sobel, Anita Stewart, Byron William Brown, Albert Bandura, Philip Ritter, Virginia M. Gonzalez, Diana D. Laurent, and Halsted R. Holman. Medical Care, 1999. Volume 37, Number 1, pp. 5-14. | |

| | |
|---|---|
| Study Participants | National, 17-state study surveying 1,170 community-dwelling chronic disease self-management program participants at baseline, and at 6 and 12 months post-program participation |
| Outcome | • 18% of participants had Emergency Room visits in the six months prior to program participation (baseline); 13% of participants had ER visits at 6 and 12 months post program participation<br>• 14% had hospitalizations at baseline, reduced down to 11% six-months later, but back up to 14% 12 months later |
| Cost-Savings | Assuming a cost of $1,513 per ER visit, and $18,750 per hospitalization, the average annual savings per participant was $713.80<br>Estimating a program participant cost of approximately $350, resulting savings averaged $363.80 per person |
| Potential Reduction in Nursing Home Stays | Since hospital stays are associated with an increased likelihood of nursing home entry, a reduction in hospital stays may be associated with a decrease in nursing home entries |
| The Impact of Chronic Disease Self-Management Programs: Healthcare Savings Through a Community-Based Intervention. SangNam Ahn, Rashmita Basu, Matthew Lee Smith, Luohua Jiang, Kate Lorig, Nancy Whitelaw, and Marcia Ory. BioMed Central Public Health Research Article on Open Access, 2013, 13:1141. | |

**Telemonitoring**

Telemonitoring, also known as remote patient monitoring (RPM), describes services where a patient's vital signs (e.g., blood pressure, weight) and other biometric data (e.g. pulse oximetry, blood glucose levels) and subjective data (e.g. disease signs and symptoms, medication and/or diet compliance) is collected by monitoring devices, typically in the patient's residence.[13] This information is electronically transferred to a clinician (provider, nurse or allied health professional) who analyzes, responds, and stores the data. Using remote monitoring and interactive devices allows the patients that need monitoring to send in vital signs on a regular basis to a provider without the need for an office visit and appropriate interventions to be discussed when needed.

Another intervention that is used to divert individuals from hospitalization and possibly nursing home admissions is the use of telemonitoring that uses easy-to-use technologies that help patients and physicians track certain conditions at home. Once tracked, the information is

[13] American Telemedicine Association, http://atawiki.org.s161633.gridserver.com/wiki/index.php?title=Remote_patient_monitoring

securely relayed to health care professionals in another location to provide assessment and treatment.

Telemonitoring is typically used for patients with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases and the need for anticoagulation. Evidence has shown that remote monitoring can improve health outcomes and reduce costs from early detection of health problems, unnecessary hospital admissions, shortened lengths of stay, and less visits to emergency room and physician offices. It could also help prevent nursing home admissions upon hospital discharge for a certain percentage of people.

State Medicaid plans have more than one option to institute permanent coverage of remote monitoring: under a federal waiver (such as for home and community-based services under Social Security Act section 1915(c)), or a new "health home" option (under section 1945) for chronic care. Currently, 12 states allow for Medicaid reimbursement of RPM: Alabama, Alaska, Colorado, Kansas, Minnesota, Massachusetts, New York, Pennsylvania, South Carolina, South Dakota, Texas, and Washington.

In Connecticut, the CHCP Waiver already includes DSS authority to receive Medicaid reimbursement for telemonitoring (under the category of assistive technology), although DSS has not implemented this service to date. In addition, states that do receive Medicaid reimbursement have enacted specific statutory language to define the conditions or diseases that will be covered and the type of clinician that can receive and analyze the data, as well as the type of contact required to discuss the results with the patient and his or her doctor.

**Connecticut proposed legislation**. The Connecticut General Assembly proposed legislation in 2015 and 2016 to provide Medicaid coverage for home telemonitoring services provided by home health care agencies for certain patients but neither bill was ultimately adopted. In 2015, the Human Services Committee reported out a bill (HB 6149) to allow DSS to seek a waiver from federal Medicaid requirements or a Medicaid state plan amendment if needed to provide such coverage and require DSS to adopt regulations, in accordance with the Uniform Administrative Procedures Act, to implement the bill's provisions.

The bill was amended by the House prior to its adoption (House Amendment "A") which: 1) allowed rather than required DSS to provide coverage for telemonitoring services; 2) limited the recipients of telemonitoring services to those Medicaid recipients in the Money Follows the Person Demonstration Grant; 3) eliminated a requirement in the original bill that DSS adopt regulations to implement the bill; and 4) added a study requirement that required the department to study the impact of telemonitoring services on factors including, but not limited to:

- health care outcomes;
- cost;
- beneficiary level of independence; and
- beneficiary quality of life.

The amendment required the department to submit a report on its findings to the Human Services Committee not later than January 1, 2017. Although the bill, as amended, passed the House unanimously, it was not taken up by the Senate.

During the 2016 legislative session, the Committee on Aging reported out SB 164, which contained identical language to the bill (HB 6149) of the previous year. It was recommitted to the aging committee. The Human Services Committee also reported out a bill (SB 115) that incorporated the language of the amended bill that passed the House in 2015. The bill, which was amended to include limiting Medicaid coverage to those services that are clinically appropriate, cost-effective, and likely to increase access to care passed on consent in the Senate but was never called in the House.

**Caregiver Education**

Caregiver education is provided by several types of providers in Connecticut. They include education provided by AAAs, through VNAs, and in hospitals and nursing homes at the time of a patient's discharge. Education provided by these organizations is described below.

**Caregiver education by AAAs**. Another important service provided by some of the AAAs is caregiver education and support. This is done by linking people to support groups, as well as teaching basic skills to caregivers so they feel more confident in providing care to a loved one. For example, the Western Connecticut Area Agency on Agency offers a free six-week course called "Powerful Tools for Caregivers." The course offers family members, friends or neighbors the tools they need to take care of themselves while caring for others. Over six weeks, participants learn to reduce stress, improve self-confidence, better communicate feelings, make tough decisions, and locate helpful resources.

Another caregiver program that has been funded, in part, by the South Central AAA is one that is operated by the VNA. It holds a multi-session community-based education service that was developed by the VNA Community Healthcare. The program provides family caregivers with the knowledge, skills, and emotional and technical support to confidently provide medical procedures and care to a person living at home.

The program has eight modules that are 1.5 hours each and has three new modules in development. It held classes in the fall of 2015 in Guilford with an average participant rate for each module of 10-15 caregivers. The program was repeated in spring of 2015 in Hamden. Evaluations completed by participants showed an extremely high level of satisfaction with classes.

**State law requiring caregiver education by hospitals and nursing homes**. In addition, recent legislation was passed in Connecticut (PA 15-32 and PA 16-59) that requires hospitals and nursing homes to provide training to caregivers at discharge of a patient. Together, the acts:

- allow a patient to designate a caregiver at or before the time the patient receives a written copy of his or her discharge plan;
- document the designated caregiver in the patient's discharge plan;
- attempt to notify the designated caregiver of the patient's discharge; and

- require hospitals and nursing homes to instruct the caregiver on post-discharge tasks with which he or she will assist the patient at home.

**Fall Prevention**

Each year in the U.S., falls are experienced by one in three adults over age 65,[14] and are the leading cause of injury for Connecticut residents 70 years of age and older.[15] There is a strong relationship between falls and nursing home admission.[16] According to the Connecticut Department of Public Health analyses of data for individuals hospitalized during 2000-2004, for example, over half of hospitalized fall patients—nearly three-quarters of whom are aged 60 and older-- were discharged to skilled nursing facilities. Falls were a contributing factor to entering long-term care in one-third of the discontinuances of CHCPE participants in CY 2008.[17]

The Connecticut Collaboration for Fall Prevention-Statewide Effort (CCFP), led by Dr. Dorothy Baker of the Yale University School of Medicine, was established in 2000 with funding from the Donaghue Medical Research Foundation in West Hartford. The overall purpose of the collaborative is to reduce the rate of falls among older adults living in the community by using the evidence-based, multidisciplinary, multifactorial[18] fall risk assessment and intervention strategy referred to as the Yale Frailty and Injury: Cooperative Studies of Intervention Techniques (FICSIT/CCFP). The initiative provides funding to programs having the goal of decreasing the rate of falls among older adults living in the community.

In SFYs 2015 and 2016, the State Department of Aging funded the state's fall prevention program, called Fall Free Living, at $475,000 per year through the Insurance Fund. For SFY 2017, the fall prevention program was appropriated $376,023 -- a $98,977 (21 percent) decrease from the past two years. One such program, the Fall Free Living Program, has gathered outcome data on 421 participants and is now described.

**Fall Free Living Program**

Visiting Nurse Association Community Healthcare in Guilford currently offers a series of community and in home fall risk screening, education and fall risk reduction exercise programs. Referred to as "Fall Free Living Program," participants receive the following program interventions:

1. Group screening/education followed by individual screenings and referrals to identify and reduce fall risks (e.g., balance and gait testing, postural blood pressures, personalized

[14] CDC, A CDC Compendium of Effective Fall Interventions: What Works for Community-Dwelling Older Adults, Third Edition, by Judy Stevens and Elizabeth Burns, 2015.
[15] Connecticut Collaboration for Fall Prevention brochure.
[16] New England Journal of Medicine, Vol. 337 (18), Falls, Injuries Due to Falls and the Risk of Admission to a Nursing Home, by Mary E. Tinetti and Christianna S. Williams, October 30, 1997.
[17] University of Connecticut Health Center, January 2010, Money Follows the Person Rebalancing Demonstration: Unmet Needs in the Connecticut Home Care Program for Elders, by Julie Robison, Noreen Shugrue, Martha Porter, Irene Reed, Rick Fortinsky, and Leslie Curry.
[18] According to Dorothy Baker, "multifactorial" means the more risk factors one has, the greater the probability of a fall.

counseling regarding use of medications, and advice regarding problems with vision, hearing, and unsafe footwear)
2. Home safety and fall risk evaluations (e.g., similar screening, but for high risk individuals who qualify for Medicare home visits)
3. Home safety equipment (e.g., shower benches and grab bars)
4. Exercise classes to reduce falls (e.g., Tai Ji Quan: Moving for Better Balance, Tai Chi for Arthritis and Sitercise based on Yale FICSIT exercises).

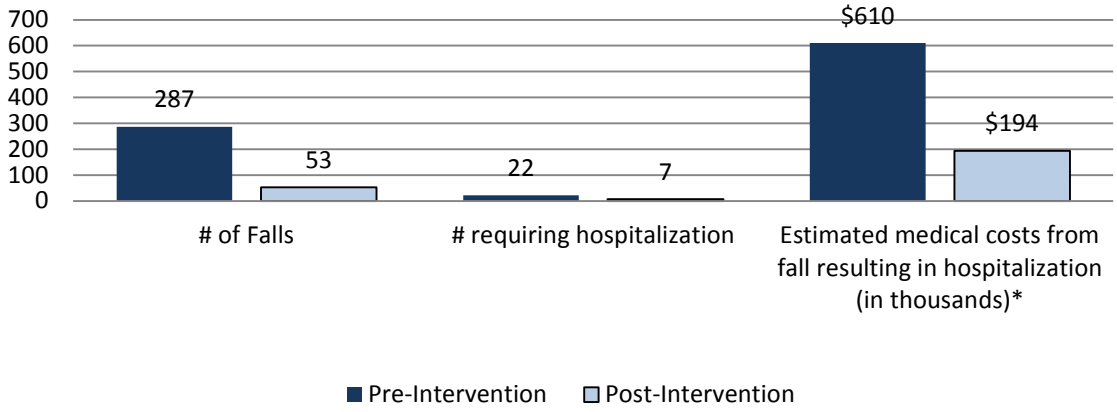
All interventions use evidence based programs and strategies, a multifactorial approach (e.g., intervenes to reduce multiple characteristics known to increase the risk of fall), and are carried out by medical professions, such as nurses, physical and occupational therapists, and pharmacists. The participants' primary care providers are informed and asked to also support interventions to reduce fall risks.

**Outcome Measures of the Fall Free Living Program**

During July 1, 2013 through June 30, 2014, a total of 795 individuals participated in the Fall Free Living Program. Self-reported information was compared regarding falls and related use of health services in the six months prior to the intervention to six months post-intervention for the 421 of the participants who had been followed the full year.

Figure 5-3 shows the number who experienced a fall before and after participating in the program, and the estimated cost.[19] The $27,745 medical cost estimate for the three-month period following a fall resulting in inpatient hospitalization include, not only the cost of the hospitalization itself, but also associated primary and specialty care office visits, radiology and laboratory tests.

**Figure 5-3. Pre-Post Data on Fall Free Living Program**




* Estimated to be $27,745 per episode.
Source: Connecticut Collaboration for Fall Prevention Narrative Report: July 1, 2013 through June 30, 2014.

[19] Cost estimate from, "A Longitudinal Analysis of Total 3-Year Healthcare Costs for Older Adults Who Experience a Fall Requiring Medical Care." Alex A. Bohl, Paul A. Fishman, Maria A Ciol, Barbara Williams, James LoGerfo, and Elizabeth A. Phelan. The American Geriatrics Society. May 2010, Vol 58 (5), 853-860.

**Cost savings.** The cost of the program was $50,202 in SFY 2014, or an average cost of approximately $63.15 for each of the 795 participants. Given that an investment of $50,202 saved an estimated $416,000 in avoided hospitalization costs, the net savings of $366,000 meant that, for each $1 spent on this fall prevention program, there was a savings of $3.66. Despite this outcome, the fall prevention program, overseen by the State Department of Aging, received a 21 percent decrease in funding in SFY 17.

**Inclusion of outcome measures in all SDA-funded fall prevention programs.** The total SFY 2017 fall prevention budget was $376,023. This relatively modest amount includes $117,991 for tai chi classes (instructors and community network), and funding for community based fall prevention clinics, exercise programs, and home safety visits. The Fall Free Living Program described in this section, had impressive outcome data. Not all SDA-funded fall prevention programs, however, include similar outcome measures. Given the limited resources for fall prevention, it is important to require outcome measures for all SDA-funded fall prevention programs for use in future funding decision making. **Therefore, PRI staff recommends:**

> **the collection and reporting on outcome data should be a requirement for recipients of funds from the Connecticut Collaboration for Fall Prevention-Statewide Effort (CCFP).**

# APPENDICES

# Legislative Program Review and Investigations Committee

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# STUDY SCOPE

## Factors Influencing Receipt of Long-Term Care Services and Supports in Home and Community Settings

## Focus

This study will examine what differentiates Connecticut residents who receive long-term services and supports (LTSS) in the community versus in nursing homes, and identify ways these findings may be used to increase efficiency and potentially reduce costs. Possible influences include: characteristics of the individuals and the nursing homes; the transition planning/process; services available in the community, including informal family supports; and payor source of LTSS.

## Background

Care of people with disabilities and older adults in long-term care facilities (i.e., nursing homes) is considered to be more expensive and often viewed as less desirable than supporting them at home or in another community setting. Long-term services and supports (LTSS) encompass a wide array of medical, social, personal care, and supportive services needed by individuals who, because of a chronic illness or condition, have lost some capacity for self-care and need help with daily activities for a lengthy period of time. In state FY 2015, the Connecticut Medicaid program spent $2.889 billion on LTSS, accounting for 15 percent of total expenditures for the state of Connecticut.[1] Given Connecticut's aging population, and the estimate that 69 percent of 65 year olds will need LTSS as they age,[2] this expense may have an increasingly larger influence on future Connecticut budgets.

Connecticut has a history of providing LTSS in nursing home settings, which is often paid for by Medicaid, requiring a 50 percent state match. In 1981, Congress adopted a provision that allowed states to receive a Medicaid waiver to correct bias toward institutional care in Medicaid services for the chronically ill, with the rationale being that individuals who would otherwise be institutionalized, could receive supports and services in their homes and communities.

In state FY 2015, 40 percent of Connecticut residents requiring LTSS were living in nursing homes, and 60 percent in home and community settings.[3] Two programs administered by the Department of Social Services provide support for community-based care for frail elderly and people with disabilities. The Connecticut Home Care Program (CHCP) is the primary vehicle used by the state to provide home and community-based care to prevent

[1] Office of Policy and Management, Policy Development and Planning Division, 2015.
[2] *Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut.* A Report from the Connecticut Long-Term Care Planning Committee to the General Assembly, January 2016.
[3] Ibid.

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institutionalization in a nursing home. The second program, called Money Follows the Person Rebalancing Demonstration (MFP)[4], supports Connecticut's efforts to "rebalance" the long-term support system, to increase the percentage of participants with long-term services and supports living in the community compared to an institution. By 2025, the goal is to have 75 percent of individuals receiving Medicaid LTSS in the community and 25 percent in institutions/nursing homes. Many state agencies, committees, and initiatives are addressing this rebalancing of long-term services and supports.

## Areas of Analysis

1. Provide overview of Connecticut's long-term services and supports structure, including:
   a. Organization
   b. Funding
   c. Service delivery
      1) Description of LTSS in home and community-based settings
         i. Individuals
         ii. Services and supports
      2) Profile of LTSS in nursing homes
         i. Criteria used to determine need for nursing home placement
         ii. Description of nursing home clients
         iii. Description of nursing homes
         iv. Description and analysis of decisionmaking process to retain or transition individuals in or out of nursing homes

2. Examine costs of care for persons with disabilities and older adults in nursing homes versus home/community care settings, including:
   a. Factors influencing cost in nursing homes vs. home/community care
   b. Cost of prevention into nursing home vs. transition out of nursing home
   c. Initial vs. ongoing costs

3. Identify factors associated with appropriately preventing initial entry into nursing homes or transitioning out of nursing homes
   a. Services provided/available through state agencies, community and private providers
   b. Informal family support
   c. Presence or absence of certain barriers
   d. Geographic location
   e. Quality/strength of transition process/planning
   f. Payor source for LTSS

4. Review promising or best practices used in other states to address LTSS for Connecticut residents

5. Explore possible ways these study findings may be used to increase efficiency and potentially reduce costs

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[4] MFP was created by Section 6071 of the federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171)

***DEPARTMENT OF SOCIAL SERVICES***
***CONNECTICUT HOME CARE PROGRAM & 1915(i) State Plan Option - FEE FOR SERVICE USE ONLY***
***rev: 03/16*** ***Effective 3/1/2016***

| ***Category Type*** | ***Description*** | ***Functional Need*** | ***Financial Eligibility*** | ***Care Plan Limits*** | ***Funding Source*** | ***Intake Status*** |
|---|---|---|---|---|---|---|
| ***Category 1 CHCPE*** | *Limited home care for moderately frail elders* | *At risk of hospitalization or short term nursing home placement ( 1 or 2 critical needs)* | ***Individual Income= No Limit**** ***Assets:*** ***Individual = $35,766.00*** ***Couple= $47,688.00*** | *<25% NH Cost* ***($1454.00 Monthly)*** | *STATE* | ***Two year f (Wait-list)*** |
| ***Category 2 CHCPE*** | *Intermediate home care for very frail elders with some assets above the Medicaid limits.* | *In need of short or long term nursing home care ( NF LOC)* | ***Individual Income= No Limit**** ***Assets:*** ***Individual = $35,766.00*** ***Couple= $47,688.00*** | *<50% NH cost* ***($2909.00 Monthly)*** | *STATE* | ***OPEN*** |
| ***Category 3 CHCPE*** | *Extensive home care for very frail elders who would other-wise be in a nursing home on Medicaid.* | *In need of long term nursing home care ( NF LOC)* | ***Individual Income=$2199.00/Mth*** ***Assets:*** ***Individual = $1,600.00*** ***Couple:*** ***both as clients = $1600.00 each*** ***one as client = $25,444.00*** ***($1600.00 + $23,844.00 CSPA)***** | *100% NH Cost* ***($5818.00 Monthly)*** ***Social Services*** *115% NH Cost* ***($6690.00 Monthly)*** *100% Subacute**** ***(11778.49 Monthly)*** *115% Subacute**** ***(13545.26 Monthly)*** | *MEDICAID WAIVER* | ***OPEN*** |
| ***Category 4 CHCPD*** | *Intermediate home care for individuals* ***under*** *age 65 with a degenerative neurological condition. ineligible for Medicaid* | *In need of short or long term nursing home care ( NF LOC)* | ***Individual Income= No Limit**** ***Assets:*** ***Individual = $35,766.00*** ***Couple= $47,688.00*** | *<50% NH cost* ***($2909.00 Monthly)*** | *STATE* | ***Wait-list*** *limited to 100 slots* |
| ***Category 5*** | ***Same as category 1.Also*** | *At risk of* | ***Individual Income - $1,485*** | | *50% Federal Reimbursement* | ***OPEN*** |

| | | | |
|---|---|---|---|
| ***1915(i)*** | ***active on categorically needy Medicaid S01, S02, S03, S04 Must be age 65 or older*** | *hospitalization or short term nursing home placement ( 1 or 2 critical needs)* | ***Assets: Individual = $1,600.00*** |

***Notes:***

*1. Clients in the higher income range are required to contribute to the cost of their care. Applied income starts at $1,980.00.*

* *2. There is no income limit for the State Funded portion. The Medicaid Waiver income limit remains at 300% of SSI which is $2,199.00.*

*3. CHCPE Services available in all categories include the full range of home health and community based services.*
**1915(i) State Plan Option has limited PCA services to 14 hours weekly and homemaking services are limited to 6 hours weekly.*

*4. Care plan limits in all categories are based on the total cost of all state-administered services.*

*5. 1915(i) State Plan option covers individuals on Medicaid but who qualify for category 1 services.*
*CT will claim 50% reimbursement from the federal government for home and community based services not reimbursable under Medicaid.*

*6. Some individuals under category 2 may become financially eligible for the Medicaid Waiver.*
*In these cases, the client must apply for Medicaid and cooperate with the application process.*

** *7. Married couples who are over this asset limit for category 3 may be eligible based on the special spousal asset protection rule.*

*8. Functional need is a clinical determination by the Department about the applicant's critical need for assistance in the following areas:*
*Activities of Daily Living (ADL's) :Bathing, Dressing, Toileting, Transferring, Eating/Feeding,*
*Needs factors : 1. Behavioral Need - Requires daily supervision to prevent harm. 2. Medcation supports - Requires assistance for administration of physician ordered daily medications. Includes supports beyond set up.*

*9. NF LOC is defined as;*
- *1. Supervision or cueing ≥ 3 ADL's + need factor*
- *2. Hands-on ≥ 3 ADL's*
- *3. Hands-on ≥ 2 ADL's + need factor*
- *4. A cognitive impairment which requires daily supervision to prevent harm*

*** *10. Subacute LOC is defined as;*
- *1. Participant requires comprehensive medical monitoring but does not require intensive diagnostic and/or invasive procedures*
- *2. Participant requires intense medical supervision and therapy such as nursing interventionintermittenly throughout the day and/or the need for ancillary or technological services(such as laboratory, pharmacy, nutrition, diagnostic)*
- *3. Participant may require services such as brain injury rehabilitation, high intensitystroke or orthopedic programs, ventilator programs, complex wound care or specialized infusion therapy.*

*11. Care Plan limits are for CHCP fee for service only*

*12. For contracted Access Agencies use only.*

## Appendix C

**AVERAGE MONTHLY MEDICAID RATES**

NH - $6966.94
CD - $33833.97
ICF/IID - $14781.59
ABI/NF - $12927.08

**Waiver Cost Caps - 2016**

**CHCPE**

CAT 3 - $5818.00 (NH AVERAGE RATE $6966.94 – AVERAGE APPLIED INCOME of $1148.59), 115% = $6690.00
CAT 2 - $2909.00 (50% of $5818.00)
CAT 1 - $1454.00 ($25% of $5818.00)

**PCA**

$5818.00 (100% NH CAP), 115% = $6690.00
$4654.00 (80% NH CAP)
$3490.00 (60% NH CAP)

**KATIE BECKETT**

NH – $5818.00
CD – $33260.37 (PER DIEM RATE OF $1112.35 X 365 / 12 = $33833.97 – AVERAGE MONTHLY AI OF $573.60)
ICF/IID – $14020.19 ($14781.59 MONTHLY - AVERAGE AI OF $761.40)
SUB ACUTE - $11778.49 ($425.00/DAY X 365 / 12 = 12927.08 – NH AI OF 1148.59)

**ABI I**

NH – $11636.00 (200% NH RATE OF $5818.00)
CD – $66520.74 (200% CD RATE OF $33260.37)
ICF/IID – $28040.38 (200% ICF/MR RATE OF $14020.19)
ABI/NF – $23556.98 (200% SUB ACUTE RATE OF $11778.49)

**ABI II**

NH - $8727.00 (150% NH RATE OF $5818.00)
CD - $49890.55 (150% CD RATE OF $33260.37)
ICF/IID - $21030.28 (150% ICF/MR RATE OF $14020.19)
ABI/NF – $17667.73 (150% SUB ACUTE RATE OF $111778.49)

**MENTAL HEALTH**

$7272.50 (125% of NH cost cap of $5818.00)

**DDS**

COMPREHENSIVE – $21030.28 (150% ICF/IID RATE of $14020.19)

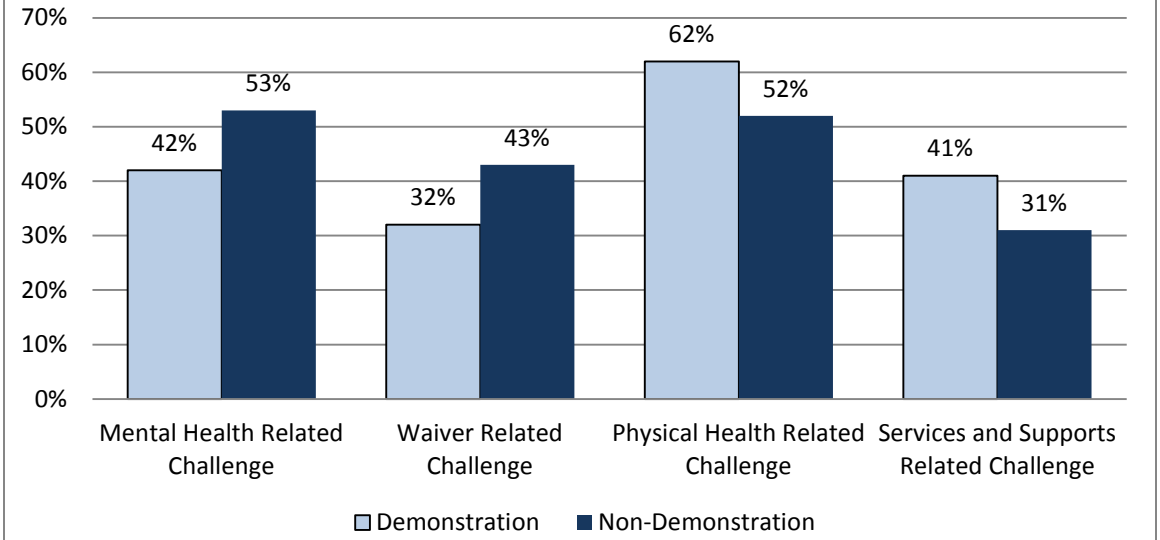
Source: Department of Social Services

# APPENDIX D

## Challenges for demonstration vs. non-demonstration MFP participants

Regardless of whether they transitioned, some of the challenges were more likely for demonstration participants (i.e., physical health, and services and supports related challenges) and some more likely for non-demonstration participants (i.e., mental health, and waiver related challenges) (Figure A-1).

**Figure A-1. Differences in Challenges for MFP Demonstration and Non-Demonstration Participants**




There were 298 critical incidents reported for the 568 demonstration participants (and 3 for the 27 nondemonstration participants). The largest number of critical incidents (261) were related to emergency room visit or unplanned hospitalization, with the next most frequent incident being untimely death (27).