Long-Term Care "Rebalancing"

Opportunities abound!

Presentation before the
Commission on
Enhancing Agency Outcomes

August 11, 2010

By: Julia Evans Starr
Executive Director
CT Commission on Aging

CoA: Turning Research into Action

CONNECTICUT COMMISSION ON AGING

CT Commission on Aging

Nonpartisan, objective, results-oriented

- Created in 1993
- CT General Statutes 17b-420
- Statute modified in 2009 to embed RBA (PA 09-7)
- Independent, citizen-driven
- Part of the Legislative Branch of Government

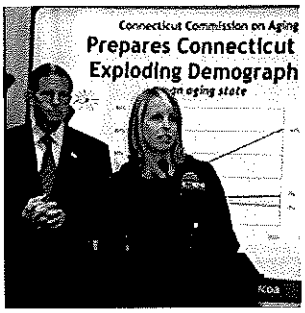
CoA Mission

prepares the state for an aging population, serves as an objective, credible source of information on issues affecting older adults of today and tomorrow, and provides accountability within state government.

Graying Demographics

In Connecticut

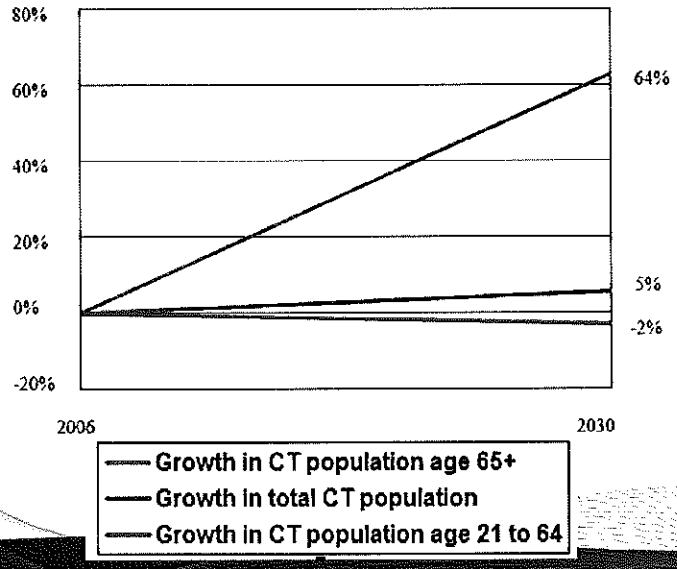
- The 7th Oldest State in the Nation
  (New Census 3rd oldest for non-Hispanic whites)
- 600,000 People Age 60 or Older
- One Million Baby Boomers:
  Nearly 1/3 of CT's Total Population



Press Conference: National Falls Prevention Awareness Day

- From 2006 to 2030: 65+ population will increase by 64%

Graying Demographics



Unprecedented Longevity

- In the early 1900's life expectancy was 47 years of age
- Flash forward to now, life expectancy has increased by 30 years
- 800 people in CT lived to be Centenarians (2000 census)
  - Roughly 664 of those were women
- A new term for age is generated -
  - "Super-Centenarians"

Ms. Emma Tillman

The Impact of an Aging and Long-lived Demographic on Local, State and National Government

Is Tremendous!

LTC Expenditures

The Need for Action

LTC Medicaid Expenditures ($2.4 Billion)
set to more than double by 2025 (without action)

- **13%** of the overall state budget.
- **49%** of the entire DSS budget.
- **53%** of the Medicaid budget.

Research and Planning

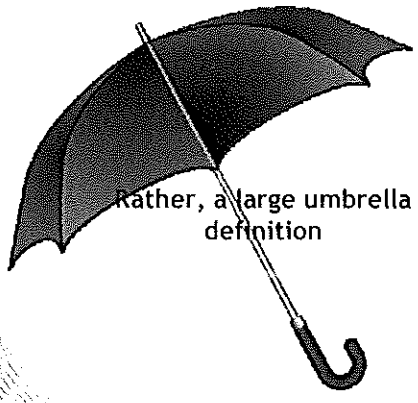
The CGA mandated and funded the Long-Term Care Needs Assessment (PA 06-188) 32 legislative co-sponsors of the original bill / in consultation with the CT Commission on Aging, the LTC Advisory Council, and the LTC Planning Committee.

LTC Needs Assessment conducted by UConn Health Center, Center on Aging. *"The most comprehensive study conducted in any state."*

Photo by Felix Planas

State LTC Plan developed every three years by the LTC Planning Committee (state agencies) and the LTC Advisory Council (consumers, providers, and advocates). Most recent plan submitted in January 2010.

LTC: The Modern Definition

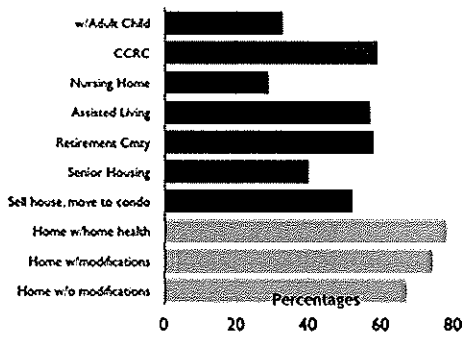


- Not Just Nursing Homes
- Not Just Insurance
- Not just for older adults

The entire range of assistance, services, or devices provided over an extended period of time to meet medical, personal, and social needs in a variety of settings and locations.

LTC: Knows no Age or Disability Boundary!

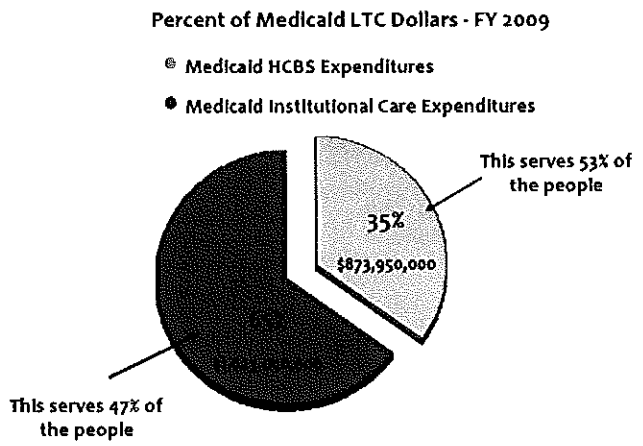
Connecticut's Residents Want to Stay in Their Homes & Communities



- 80% of people want to stay in their homes (and communities)
- Living with an adult child is just slightly more appealing than moving to a nursing home

Source: LTC Needs Assessment

CT Medicaid LTC Expenditures
HCBS & Institutional Care



CT Ranks 34th in HCBS Spending

Percent of Medicaid LTC Spending for HCBS
FY 2007

State	Percent	U.S. Rank
U.S	41.7	
New Mexico	72.9	1
Oregon	72.7	2
Arizona	64.0	3
Maine	51.4	11
New York	47.4	12
Rhode Island	45.6	14
New Hampshire	39.6	25
Massachusetts	38.7	28
Connecticut	35.5	34
Pennsylvania	28.3	48
North Dakota	25.6	49
Mississippi	12.7	50

Source: Brian Burwell et al; Medicaid LTC Expenditures FY 2007; September 2008

Long-Term Care Reform or "Rebalancing"

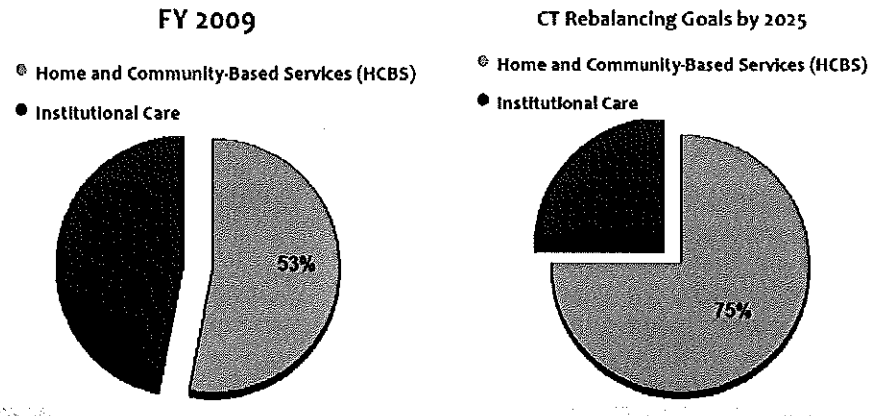
Changing the focus and funding priorities to home and community-based supports.

- ***CT would spend $600 - 900 million less every year** - with a more progressive system.
- honors individuals' rights and their desires - 80% of CT residents want to age in their homes & communities
- is consistent with the ADA, the US Supreme Court Olmstead Decision and Connecticut law (PA 05-14)
  people have the right to choose and receive care in the least restrictive environment.
- is consistent with national trends/policy directions
- Problem: Medicaid rules require states to pay for nursing home care while home and community-based services are "optional".

Sources: LTC Needs Assessment & CT LTC Plan 2010

% of People in CT Receiving Medicaid LTC

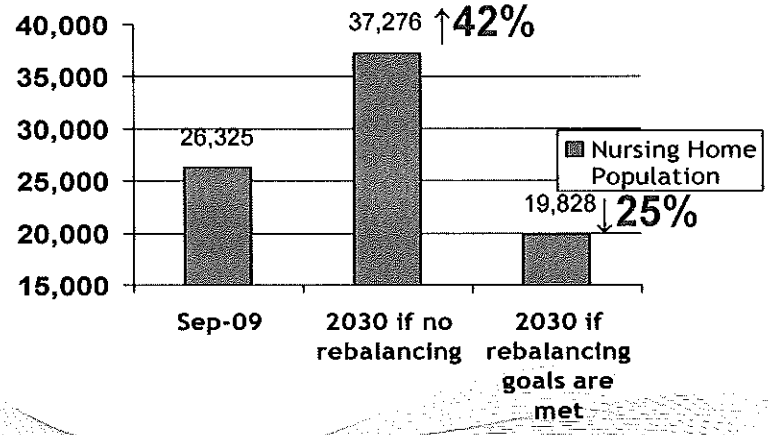
HCBS vs. Institutional Care



Sources: LTC Plan & LTC Needs Assessment

Nursing Home Projections for 2030

The need for nursing home beds in the future is dependent upon policy decisions made both federally and in our state.



Source: UConn Health Care Center, Center on Aging, August 2010

Money Follows the Person

MFP: A multi-million dollar demonstration grant from the federal *government...rebalancing in action.*

255 persons transitioned from 96 different nursing homes.

- The highest number of persons transitioned from any single nh was 11.
- 60% people under the age of 65.

1356 applications received, representing residents in 170 different skilled nursing facilities

CoA: Helps bridge the gap between Executive and Legislative Branch / Chairs the MFP Steering Cmte. / Chairs and manages the Workforce Subcommittee: developing a strategic plan with a goal of 9,000+ HCBS jobs within the next 5 years.

Guiding Principles
Long-Term Care Needs Assessment

Guiding Principles: Create parity among age groups, across disabilities, and among programs through allocating funds equitably among people based on their level of need rather than on their age or type of disability.

Break down silos that exist within and among state agencies and programs. Use the model of systems change grants such as a the Money Follows the Person Grant and the Medicaid Infrastructure Grant to foster integration of services and supports.

LTC Needs Assessment
Recommendations

1. Create a single point of entry or no wrong door.
2. Provide a broader range of community-based choices.
3. Foster flexibility in home care delivery.
4. Address scope and quality of institutional care.
5. Provide true consumer choice and self-direction to all LTC users.
6. Simplify CT's Medicaid structure.
7. Create greater integration of functions at the state level and consider alternative configurations of state government structure. Establish a consolidated, efficient all ages human services approach to LTC in CT.

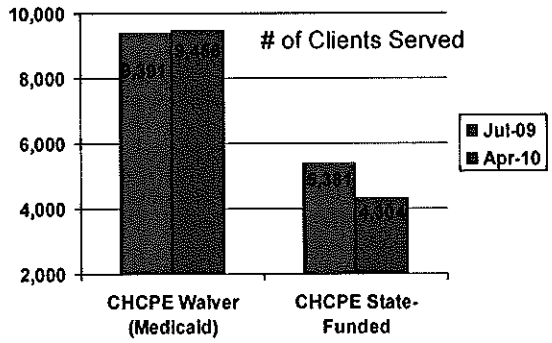
LTC Needs Assessment
Recommendations

8. Address education and information needs of the CT public.
9. Increase availability of ready accessible, affordable transportation (and housing).
10. Address LTC needs of persons with mental health disabilities.
11. Address access and reimbursement for key Medicaid services.
12. Expand and improve vocational rehabilitation for persons w/ disabilities.
13. Address the LTC workforce shortage.
14. Provide support to informal caregivers.
15. Continue to expand efforts to build data capacity and systems integration in the service of better management and client service.

Build HCBS
Implications of Policy Decisions

CT Home Care Program for Elders

Over 1,000 people dropped off the program



$79,205 = nh cost/year (Medicaid)
$19,716 = CHCPE cost/year (Medicaid)

$59,489 = difference in cost per person per year

Beginning January, 2010, as a result of PA 09-5, a 15% cost-share was required for CHCPE state-funded clients. (Effective July 2010 it was reduced to 6% based on PA 10-179).

If one estimates that 15% of those that dropped off the (state-funded) CHCPE entered nursing homes, the cost to the state is approximately $9.6 million more than if they had continued on the CHCPE. *Note: OFA estimated 15% cost-share would save $10 million.*

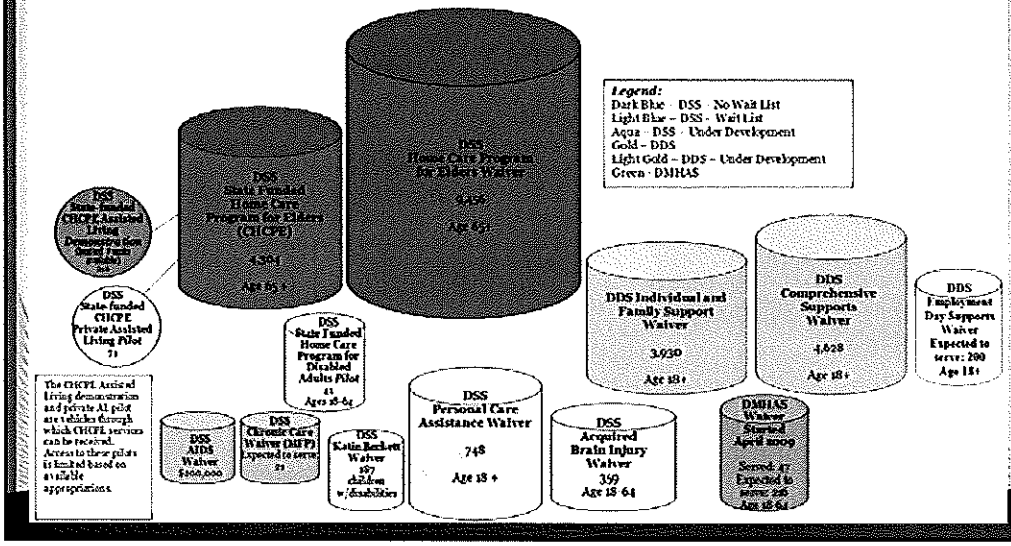
Chart source: DSS, July 2009, & April 2010 CHCPE Monthly Report

Break Down the Silos

Streamline the Home and Community-Based System

To utilize Medicaid to pay for HCBS, you must fit into one of these narrowly defined waivers (or related state-funded pilots)

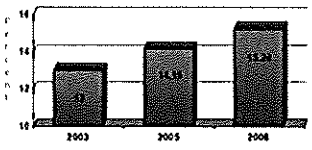
National experts say "CT has too many waivers."



Target areas ripe for improvement & cost savings

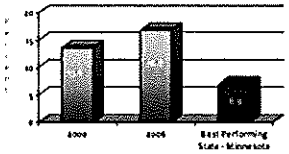
featured in CoA's Results-Based Accountability Report to the Legislature (PA 09-7)

Percent of all hospital discharges to nursing homes vs. home settings



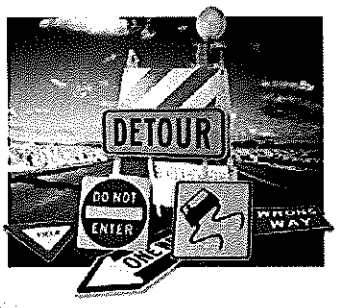
Story Behind the Baseline: 15% of people leaving hospitals in 2008 were discharged into institutions instead of a home setting, a trend that has increased over the years. Data show that 66% of individuals on Medicaid who enter nursing homes are still there after six months. Additionally, discharge placements vary widely depending on the hospital.

Percent of long-stay nursing home residents with a hospital admission



Story Behind the Baseline: In 2006, almost 17% of nursing home residents in CT had to be hospitalized for a health condition, leading to disruption, decreased quality of life and increased costs. Unfortunately, CT is headed in the wrong direction--with a 22% increase this data point from 2000. If CT performed at the level of the best-performing state (MN), it would have increased quality of care and saved an estimated $17 million.

Major Roadblocks to Reform



Complexity / Turf
Fragmented system / Avoidance
Interest Group Lobby
Gaps in Services
Confusion / Fear Factor
Limited Choices / Personal Cost
Two Year Election Cycle
Adult Children's Expectations

Potential Motivators

- Commission on Enhancing Agency Outcomes
- The movement to streamline state systems
- Opportunities for LTC Reform contained in Affordable Care Act
- New state leadership at the very top
- Elevated interest by the business community
CT Regional Institute for the 21st Century & CBIA
- Movement to maximize state and federal $$
- RBA
- The economy

21st Century Presser

CoA/LTCAC Affordable Care Act Forum

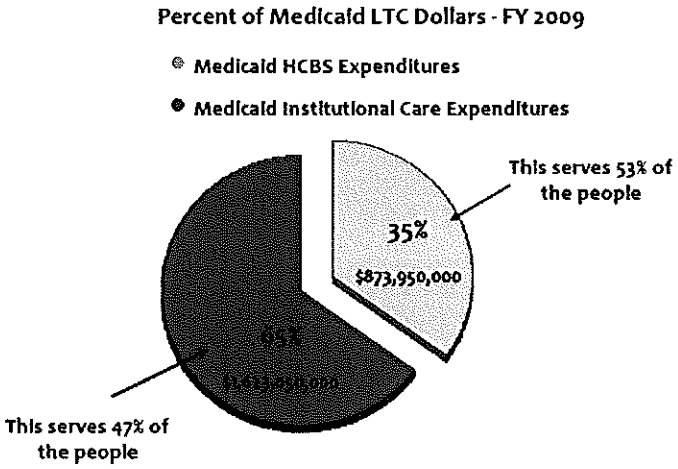
Money Follows the Person (MFP): The Whole Picture!

MFP is a 56 million dollar federal demonstration grant, received by the CT Department of Social Services, that is intended to rebalance the long-term care system so that individuals have the maximum independence and freedom of choice where they live and receive services.

MFP is a systems change project aimed at rebalancing the long-term care system. While very important, transitioning 890 (up to 5,000) people with disabilities and older adults out of nursing homes and back into the community is only one of five major goals of MFP.

Five Major Goals (benchmarks) of MFP:

1. **Increase dollars spent on home and community based services.** *This increase will help ensure that community- based options are available to help all people, not just MFP participants.*
2. **Increase the number of people living in community:** Increase the percentage of people receiving long-term care services in the community relative to the number of persons in institutions.
3. **Increase hospital discharges to community:** Decrease the number of hospital discharges to nursing facilities among those requiring care after discharge. *Data available through MFP shows that people who are Medicaid eligible have a high likelihood of never being able to leave an institution once discharged from a hospital.*



4. **Increase the probability of returning to the community:** Increase the probability of people returning to the community within the first six months of admission to an institution.
5. **Transition people from institutions to the community:** Transition 890 (up to 5,000) individuals out of institutions back into the community. 60% of those transitioned will be younger persons with disabilities, 40% will be people over the age of 65+.

Major Systems Change Intiatives: The MFP steering committee and staff are working on major systems change intiatives that will help the project meet its benchmarks. These initiatives include:

- **Workforce Development** (CoA serves as chair) – developing a strategic plan to address the home and community-based workforce shortage. MFP will begin implementing low-cost activities based on the plan;
- **Hospital Discharge Planning** – training and piloting nursing home diversion activities with hospital discharge planners;
- **Quality Improvement** – creating emergency back-up systems for MFP participants. In addition to providing proper emergency back-up services, data collected through this system will be used to identify and address challenges of community living;
- **Housing** – working with other state agencies to increase the amount of available accessible housing.

For more information, please contact the Connecticut Commission on Aging, at 860-240-5200.
The CoA's Executive Director serves as co-chair of the MFP steering committee.

Facts about Connecticut Nursing Homes (August, 2010)

CONNECTICUT COMMISSION ON AGING

General Statistics

- There are 240 nursing homes, also known as "skilled nursing facilities" in the State of Connecticut. The break-down is as follows[1]:

	For Profit	Not for Profit	Total
Unionized Staff	71	12	83
Nonunionized staff	114	43	157
Total	185	55	240

- As of 9/30/09, there were 26,325 nursing home residents in Connecticut.[2]
- As of 9/30/09, there were 28,994 nursing home beds in our state, with an average occupancy rate of 91%. This occupancy rate varies by region: Windham County has the highest average occupancy rate (95%), while Hartford, Middlesex and New London counties' occupancy rate is 90%. [3]
- Age of residents: 12% under the age of 65, 39% between 65 and 84, 49% aged 85+. [3]
- Payment source: 69% are covered by Medicaid, 16% by Medicare, 11% by private "out of pocket" funds and the remainder by private insurance or the VA. [3]
- Average Medicaid rate per day: $217 (~$79,205 annually) in FY '09. [4] The state spends $1.3 billion in Medicaid funds on nursing home care annually.
- Average Private Pay rate per day: $341 (~$124,000 annually) [3]

Oversight

- Skilled nursing facilities are licensed by the state Department of Public Health, which conducts inspections at least once per year.
- The federal Center for Medicare and Medicaid Services (CMS) also certifies nursing homes for both Medicare and Medicaid.
- Medicaid rates are determined by the state Department of Social Services.
- The state Long-Term Care Ombudsman Program protects the health, safety, welfare and rights of long-term care residents. The office investigates complaints and concerns made by residents, or on behalf of residents, in a timely and prompt manner and helps residents voice their concerns directly to public officials on issues affecting their lives.

---

[1] Deborah Chernoff, SEIU 1199

[2] 2010 State of Connecticut Long-Term Care Plan.

[3] State of Connecticut Annual Nursing Facility Census (September 30, 2009)

[4] Presentation by Commissioner Michael Starkowski (October, 2009)

Trends

- Number of beds: declined by 3% since 2004 [3]
- Number of residents: decreased by 5.3% since 2004[3]
- Resident demographics: Gender split has remained consistent. However, since 1999, age has trended downward: the number of residents aged 55-64 has increased by 49%, while the number of residents aged 75-84 has decreased by 24%. [3]
- Occupancy rate: decreased for all eight counties over the past five years [3]
- For-profit status: 3% more facilities are for-profit than were five years ago [3]

Financial Distress

- In the past several years, nursing homes have faced increasing financial difficulties, leading to bankruptcies, closures and uncertainty. Six nursing homes have closed across the state since September, 2008.
- DSS must approve all closures. Courtland Gardens (in Stamford) was recently denied its application to close.

Projected Need

- There is currently a moratorium on new nursing home beds.
- The need for nursing home beds in the future is dependent upon policy decisions made both federally and in our state.

  New projections from the University of Connecticut Health Center, Center on Aging demonstrate huge shifts in nursing home population based on the percentage of individuals receiving long-term care in home-care settings vs. nursing home settings.

  Currently, 53% of individuals receiving long-term care through Medicaid receive home- and community-based care, while 47% receive care in nursing homes. Connecticut's goal, articulated in the 2010 Long-Term Care Plan, is to "rebalance" the system so that, by 2025, 75% of individuals receive care in the community, while 25% are in nursing homes.

  Their projections, based on a number of assumptions, are:

Nursing Home Population in CT (9/30/09)	Projected NH Population in 2030 **WITH NO REBALANCING**	Projected NH Population in 2030 **IF REBALANCING GOALS ARE MET**
26,325	37,276 **(increase of 42% from 9/30/09)**	19,828 **(decrease of 25% from 9/30/09)**