

# An Updated Assessment of Connecticut's Long-Term Services and Supports System

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A PRESENTATION OF THE  
CONNECTICUT INSTITUTE FOR THE 21<sup>ST</sup> CENTURY  
FEBRUARY 2016



# Executive Summary (1 of 2)

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- Connecticut's delivery of long-term services and supports (LTSS) has increased the percentage of clients receiving services in their homes and communities from 53% to 60% relative to those utilizing institutional care since 2009.
  - However, the state is still significantly far from its stated desired ratio of those utilizing home- and community-based care (HCBS) versus institutional care (75:25). Serving 75% of clients in a home or community setting could produce savings of \$657 million.
- The state has increased the number and variety of programs providing LTSS and has taken advantage of several additional federal funding sources.
- The population needing LTSS will increase dramatically in the near future as Baby Boomers age.
  - This has the potential to severely impact the state's fiscal situation.
- It will be important to continue current programs and initiate additional improvements in order to reach the optimal percentage of services delivered through HCBS.
  - This will limit the budgetary impact of the aging population.

# Executive Summary (2 of 2)

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- To that end, this report highlights recommendations to increase the percentage of state LTSS provided through HCBS, including:
  - Establish LTSS Coordinator
  - Broaden Scope of LTSS Planning
  - Develop Plan for Increasing Size of LTSS Workforce
  - Expand LTSS-HCBS Awareness Campaign
  - Continue Process of Restructuring Provider Reimbursement Rates
  - Develop Single Source of Data
- This report also explores best practices from four states that were highlighted as leaders on at least one dimension of LTSS provision.

# Background

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- Connecticut's philosophy for long-term care was enacted in statute in 2005: "That Connecticut's long-term care plan and policy must 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."

Source: C.G.S. Section 17b-337 added by P.A. 05-14, effective October 1, 2005

- The Connecticut Institute for the 21<sup>st</sup> Century (CT21) commissioned the Connecticut Economic Resource Center (CERC) to update a previous report, "Assessment of Connecticut's Long Term Care System." That report was originally published in March 2010 and produced by BlumShapiro.
- CT21 has conducted research on a number of important state public policy issues and published results to provide information and recommendations that generate discussion and action that enhance the state's overall competitiveness.
- CERC is a public-private partnership that provides economic development services consistent with state strategies, leveraging Connecticut's unique advantages as a premier business location.

# Approach

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- To update the previous CT21 report on Long-Term Care (now Long-Term Services and Supports, or LTSS), CERC performed the following work:
  - Interviewed key stakeholders (identified in consultation with CT21 and BlumShapiro)
  - Reviewed recent literature, including best practices
  - Focused on national issues and their effects on Connecticut
  - Highlighted progress made within state since last report
  - Identified revised recommendations

# Interviews

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- Nora Duncan, State Director, AARP Connecticut
- John Erlingheuser, Associate State Director Advocacy, AARP Connecticut
- Claudio Gualtieri, Associate State Director Advocacy, AARP Connecticut
- David Guttchen, Director, Connecticut Partnership for Long-Term Care
- Dawn Lambert, Project Director, Money Follows the Person, Connecticut Department of Social Services
- Christopher Lavigne, Director, Reimbursement and Certificate Need Unit, Connecticut Department of Social Services
- Deb Migneault, Senior Policy Analyst, Connecticut's Legislative Commission on Aging
- Terry Greco Nash, Manager II, Multifamily, Connecticut Housing Finance Authority
- Alice Pritchard, Ph.D., Executive Director, Connecticut Women's Education and Legal Fund
- Julie Robison, Ph.D., Associate Professor, UCONN Center on Aging
- Julia Evans Starr, Executive Director, Connecticut's Legislative Commission on Aging

# Glossary

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- **Long-term services and supports (LTSS)** – “refer to a broad range of paid and unpaid services for persons who need assistance due to a physical, cognitive or mental disability or condition. LTSS consist largely of personal assistance with the routine tasks of life as well as additional activities necessary for living independently at home, at work, at school and at recreational activities. Unlike medical care where the goal is to cure or control an illness, the goal of LTSS is to allow an individual to attain and maintain the highest reasonable level of functioning in the course of everyday activities and to contribute to independent living.” LTSS was formerly known as “long-term care” or “LTC.”
- **Home and community-based care (HCBS)** – “encompasses home care, adult day care, respite, community housing options, transportation, personal assistants, assistive technology and employment services.”
- **Institutional care** – “includes nursing facilities, intermediate care facilities for people with mental retardation (ICF/MRs), psychiatric hospitals, and chronic disease hospitals.”

Source: CT 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.

# Glossary (cont.)

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- **Informal caregivers** – provide care without pay and often consist of family members or friends. AARP estimates there were over 40 million unpaid caregivers in the U.S. in 2013, and 459,000 in Connecticut during that time. The economic value of caregiving in the state was almost \$6 billion.

Source: Susan C. Reinhard, Lynn Friss Feinberg, Rita Choula, and Ari Houser. "Valuing the Invaluable: 2015 Update." AARP Public Policy Institute, July 2015.

- **Formal caregivers** – paid caregivers in both HCBS and institutional environments. There were an estimated 50,000 paid caregivers in the state in 2012.

Source: Susan C. Reinhard, Lynn Friss Feinberg, Rita Choula, and Ari Houser. "Valuing the Invaluable: 2015 Update." AARP Public Policy Institute, July 2015.

- **Rebalancing** – increase the proportion of LTSS spending in HCBS settings rather than institutional settings.

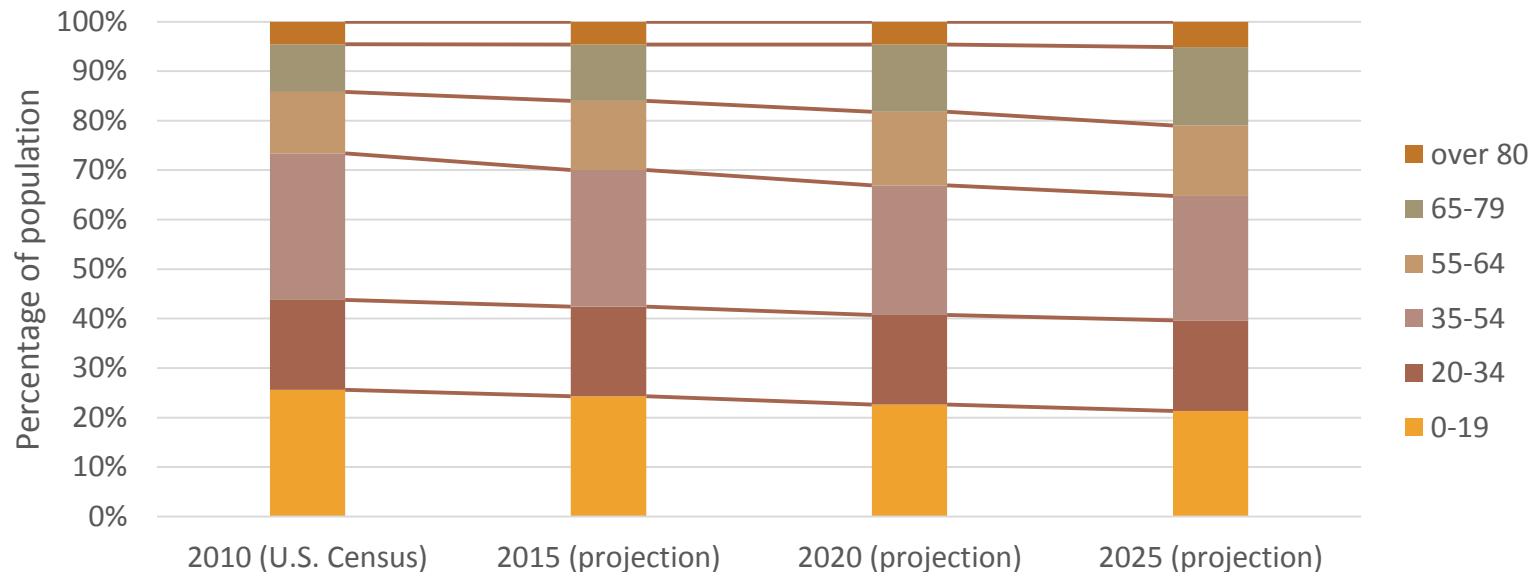


# Section 1: Introduction

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# The Continuing Need for LTSS Rebalancing

- As the Connecticut population ages, demand for LTSS will grow.



Source: Mercer, "State of Connecticut Medicaid Long Term Care Demand Projections, August 12, 2014".

- While Connecticut's population is projected to grow slightly over the next 25 years, this growth will primarily be among those over age 65.
- In the state, 79% of women and 58% of men over 65 years old will need LTSS. They will need an average of three years of assistance, and needs typically increase with age.

# Status of LTSS Population in CT

Medicaid LTSS	Number of monthly clients (2009)	Number of monthly clients (2015)	% change, number of clients (2009-2015)	Annual expenditures (2009)	Annual expenditures (2015)	% change, annual expenditures (2009-2015)
Community-based care	21,275 (53.1%)	27,341 (59.6%)	21.5%	\$866 million (35.5%)	\$1,311 million (44.4%)	33.9%
Institutional care	18,822 (46.9%)	18,516 (40.4%)	-1.7%	\$1,612 million (64.5%)	\$1,643 million (55.6%)	1.9%
Total	40,097	45,857	12.6%	\$2,498 million	\$2,954 million	15.4%

Source: 2009 data: CT Long-Term Care Planning Committee. "Long-Term Care Plan: A Report to the General Assembly." January 2010. Data from OPM. 2015 data: CT 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.

- The average monthly number of Medicaid LTSS clients increased by over 5,700 people from 2009 to 2015. Costs increased by \$456 million.
  - The monthly average number of individuals in institutional care decreased by 306 clients. Although only 40% of recipients were in institutional care, this represented over 55% of expenditures.
- CT spending on Medicaid LTSS was 15% of total state expenditures and 40% of state Medicaid spending in Fiscal 2015.

Source: CT 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.

- Both state and national surveys have found that Americans desire to "age in place," rather than live in a nursing home.

Sources: University of Connecticut Health Center's Center on Aging. "Connecticut Long Term Care Needs Assessment." June 2007. Teresa A. Keenan, Home and Community Preferences of the 45+ Population. AARP. November 2010.

# Effect of CT LTSS Rebalancing

Demand for services	Nursing facilities	Home and Community Based Services	Total
2013	16,042 (43.4%)	20,897 (56.6%)	36,939
2025 (projection), pre-intervention	20,201 (43.1%)	26,652 (56.9%)	46,853
2025 (projection), post-intervention	11,651 (24.9%)	35,201 (75.1%)	46,852

Source: Mercer, "State of Connecticut Medicaid Long Term Care Demand Projections, August 12, 2014".

- It is estimated that almost 47,000 individuals will need LTSS in 2025, an increase of almost 10,000 from the number of actual recipients in 2013.
  - Prior to the state's rebalancing efforts, the proportion of recipients selecting HCBS rather than institutional care increased approximately 0.5-0.75% annually. State rebalancing has increased this rate significantly.

Source: Mercer, "State of Connecticut Medicaid Long Term Care Demand Projections, August 12, 2014".

- "A 2011 analysis of adults age 31 and over using Medicaid LTSS shows that Connecticut has the highest or the second highest nursing home rate per 1,000 population in each of the following categories in both 2000 and 2008: total state nursing home rate of use, rate of use for ages 31-64 and rate of use for age 65 and older."

Source: CT DSS, "Strategic Rebalancing Plan: A Plan to Rebalance Long Term Services and Supports, 2013-2015"

# Effect of CT LTSS Rebalancing

	HCBS*	Institutional care	Total
Current client ratio, 2015	60%	40%	
2025 expenditures with 2015 client ratio	\$2.896 billion	\$3.714 billion	\$6.610 billion
Cost increase, 2015 to 2025	\$1.585 billion	\$2.072 billion	\$3.657 billion
Optimal rebalancing client ratio, 2025	75%	25%	
2025 expenditures with optimal client ratio	\$3.643 billion	\$2.311 billion	\$5.954 billion
Cost increase, 2015 to 2025	\$2.332 billion	\$0.668 billion	\$3.000 billion

*\*Chart does not reflect likely increased costs from federal rule change in 2015 concerning home care workers.  
Source: CT 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, page 48. Data in table sourced from: OPM analysis based on data from DSS, American Community Survey, and Connecticut State Data Center.  
Expenditures include annual 5% compound rate increase.*

- Increasing the proportion of LTSS clients served in HCBS to 75% would produce savings of **\$657 million** in 2025 compared to costs at the current client ratio, assuming a constant number of recipients in 2025.

Source: CT 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. Data in table sourced from: OPM analysis based on data from DSS, American Community Survey, and Connecticut State Data Center

- This would help limit the budget impact of the increased demand for LTSS due to the aging population.

# Changing Playing Field of LTSS

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- State strategic plan will be issued in 2016
- New state programs
  - Includes Rightsizing Initiative and Strategic Plan\*, Aging in Place Task Force\*, Livable Communities Initiative\*, Community First Choice\*
  - CT Department on Aging established in 2013
- Unionization of home care workers in state
  - General Assembly approved bill in 2012
- End of federal Money Follows the Person\* demonstration grants
  - Final funding round in 2016; funds can be used through 2020
  - DSS committed to continuing these programs after demonstration funding ends
- Implementation of federal rule requiring home care agencies to pay minimum and overtime wages. Rule went into effect January 1, 2015.
  - While full budgetary effect of the change is unknown at this time, it is estimated that weekly pay for a live-in aide in Connecticut could increase from \$875 per week to \$1,066 per week

Source: Mara Lee. "A New Pay Rule Threatens To Throw Home-Care Industry Into Turmoil." *Hartford Courant*. 10/11/2015.

\* These programs are discussed more in the next section.

# Projected Monthly Cost of Care in CT

	2012	2027 (percent change)
Home care – Homemaker services	\$3,623	\$3,772 (4.1%)*
Home care – Home health aide	\$4,004	\$3,862 (-3.6%)*
Adult day health care	\$1,733	\$2,589 (49.4%)
Assisted living facility – Private one bedroom	\$5,000	\$10,865 (117.3%)
Nursing home – Semi-private room	\$11,771	\$20,067 (70.5%)
Nursing home – Private room	\$12,638	\$21,890 (73.2%)

- Costs for all types of LTSS care expected to increase significantly over next 15 years
  - Note that changes in costs of home care are likely understated, since estimates pre-date federal rule change on wages for home health care workers

Source: U.S. Department of Health and Human Services, Administration on Aging. "Costs of Care in Your State." Data sourced from: Genworth Cost of Care Study 2013.

# Where CT Ranks

	Total Medicaid LTSS spending, Fiscal 2013	Percent spent on HCBS LTSS	State rank (percent spent on HCBS)
Oregon	\$1,678 million	78.9%	#1
Minnesota	\$3,910 million	73.6%	#2
Alaska	\$534 million	70.0%	#3
Vermont	\$372 million	68.3%	#4
Arizona	\$1,573 million	68.3%	#5
...			
Connecticut	\$3,144 million	45.1%	#34
...			
Mississippi	\$1,509 million	25.5%	#50

Source: Truven Health Analytics. "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending." June 30, 2015. page 30.

- CT ranks 12<sup>th</sup> out of 51 states and D.C. on 2014 LTSS Scorecard
  - 4<sup>th</sup>: Affordability and Access
  - 6<sup>th</sup>: Quality of Life & Quality of Care
  - 22<sup>nd</sup>: Choice of Setting and Provider
  - 30<sup>th</sup>: Support for Family Caregivers
  - 39<sup>th</sup>: Effective Transitions

Source: AARP, the Commonwealth Fund, and the Scan Foundation. "Connecticut State Scorecard."



# Section 2: Current State Programs

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# Money Follows the Person (MFP)

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- Goal is rebalancing, or transitioning individuals from nursing facilities to home and community-based care
  - Rightsizing Initiative – strategic plan developed under MFP
- Pilot program for presumptive eligibility – allows clients to access HCBS services while Medicaid applications processed
  - Helps move hospital discharges to community, not nursing facilities
- Program benchmarks:
  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 percentage of long term care participants living in the community compared to an institution

Source: CT 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 2013.

# MFP Growth

	Total residents transitioned	Percent served in HCBS
2009	162	53%
2010	315	54%
2011	434	55%
2012	510	56%
2013	613	58%
2014	596	59%

*Source: UConn Health, Center on Aging. "CT Money Follows the Person Quarterly Report: Quarter 3, 2015: July 1, 2015-September 30, 2015."*

# End of Federal MFP Funding

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- Final round of federal funding in 2016
  - Funds can be used through 2020
- Sustainability plan submitted to Centers for Medicare & Medicaid Services (CMS) in 2015
  - DSS will continue administering transitional program
  - Includes access to Specialized Care Manager, Transition Coordinator, and Housing Coordinator (if needed)
  - Retain MFP services: transitional funds; addiction services and supports; informal caregiver supports; peer supports; transitional recovery assistant

*Source: Legislative Office Long-Term Care Planning Committee Meeting, "Medicaid Long-Term Services and Supports Rebalancing Initiatives," September 15, 2015.*

# Community First Choice (CFC)

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- Program launched July 1, 2015
  - Application online in July 2015
- Part of Medicaid (included in Affordable Care Act)
  - No waiting list or cap on number of participants
- Must meet nursing home level of care in community
  - Client directs own budget and assistance staff
  - Client hires personal care assistants (PCAs) without state-imposed qualifications
  - Case managers function as advisors for clients, rather than directing services
    - reduces client dependence on state for planning

# Balancing Incentive Program (BIP)

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- Enhanced federal match for HCBS
  - Amount provided dependent on state's percentage of HCBS funding (versus nursing facilities) in 2009
  - CT's total award = \$77 million, most awarded in December 2012
- Program's focus is "person-centered system" providing information on and access to LTSS programs in various agencies

*Source: Legislative Office Long-Term Care Planning Committee Meeting. "Medicaid Long-Term Services and Supports Rebalancing Initiative." September 15, 2015.*

- Program requirements include:
  - Development of "no wrong door" or "single point of entry" system
  - Pre-screening and comprehensive assessment for those entering LTSS
  - "Conflict-free case management" – i.e., limit conflict of interest between assessment and care development
  - New supports and services to help individuals remain in the community

*Source: CT 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*

# Select Other Programs

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- Nursing Facility Diversification/ Rightsizing Grants (part of MFP)
  - 2-year awards to facilities to develop alternative business models
  - Facilities must work with community to prepare applications
- Nursing facility beds moratorium extended indefinitely in 2015
- Testing Experience and Functional Tools (TEFT) grant (funding in 2014 for five years)
  - Tests quality measurement tools and demonstrates use of Personal Health Records and electronic LTSS
  - CT one of nine states participating
- CT Partnership for Long-Term Care
  - More than 58,000 LTC insurance policies sold as of June 30, 2015 and 2,600 utilized the benefits

*Source: CT 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*

# Select Other Programs (cont.)

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- Aging in Place Initiative (began in 2012)
  - Initial task force dealt with issues including: infrastructure, transportation, zoning for nursing homes, nutrition programs, fraud and abuse protections, and tax and other incentives for providers
  - State Departments of Aging and Social Services to deliver report on nutrition by July 2016
- Livable Communities Initiative (began in 2013)
  - Commission on Aging instructed to develop community partnerships and investigate innovative approaches and funding sources
- CT Home Care Program for Elders
  - Provides assistance with daily living activities for those at risk of nursing home placement
- Aging and Disability Resource Centers (ADRCs; “Community Choices”)
  - Links older adults, those with disabilities, and caregivers to services
  - 12 sites throughout state



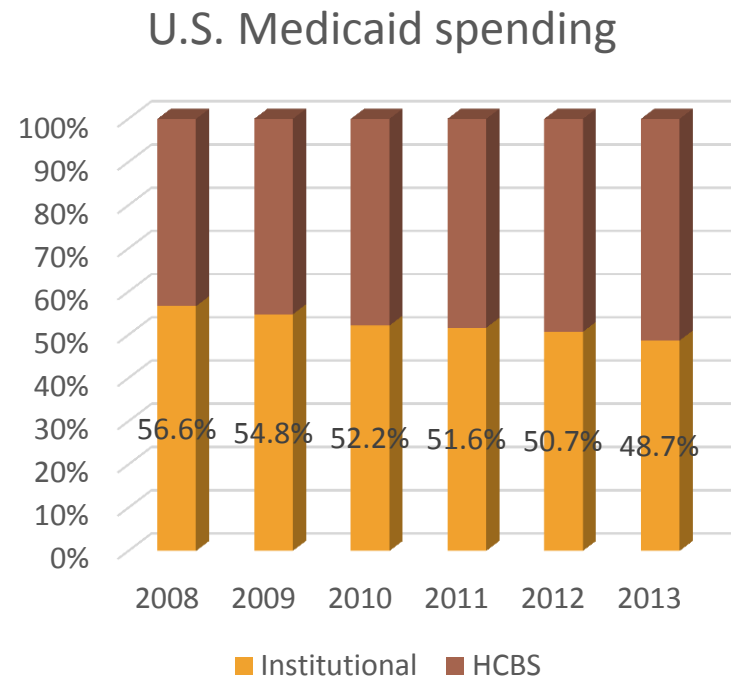
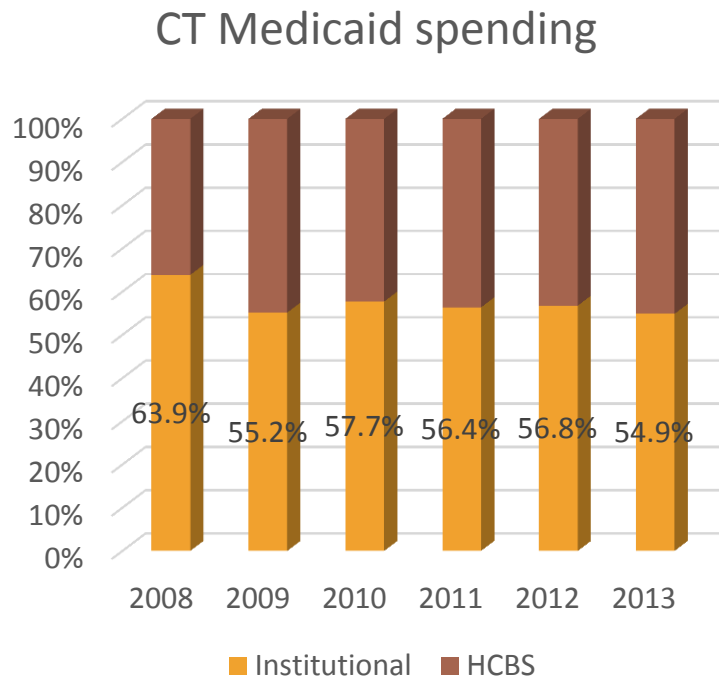
# Section 3:

## Update on Strategic Rebalancing Goals

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*These strategic goals were included in the previous CT21 report and are included in the Connecticut Long-Term Care Planning Committee's reports to the General Assembly.*

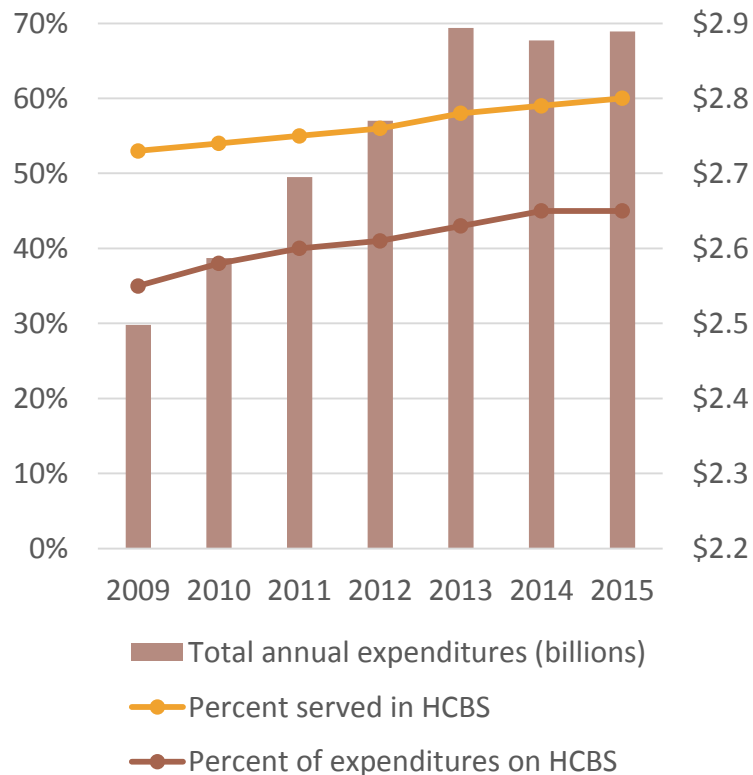
# #1: Balance the Ratio of Home and Community-Based and Institutional Care



Source: Truven Health Analytics. "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending." June 30, 2015. Note that this data may reflect prior period adjustments to previously reported data.

- **Status:** CT continues to increase the percentage of LTSS spending in an HCBS setting. State rebalancing has slightly outpaced that of the United States, although the state started with a higher percentage receiving institutional care.

# CT Medicaid LTSS Spending



- The percentage of CT residents receiving LTSS in HCBS versus institutional care has increased from 53% to 60% since 2009.
- At the same time, the percentage of state spending on HCBS versus institutional care increased from 35% to 45%.
- Overall expenditures have also increased since 2009 by 15.6%, due to the increased number of Connecticut residents served.

Source: CT 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. Data sourced from: OPM.

# #2: Balance the Ratio of Public and Private Resources

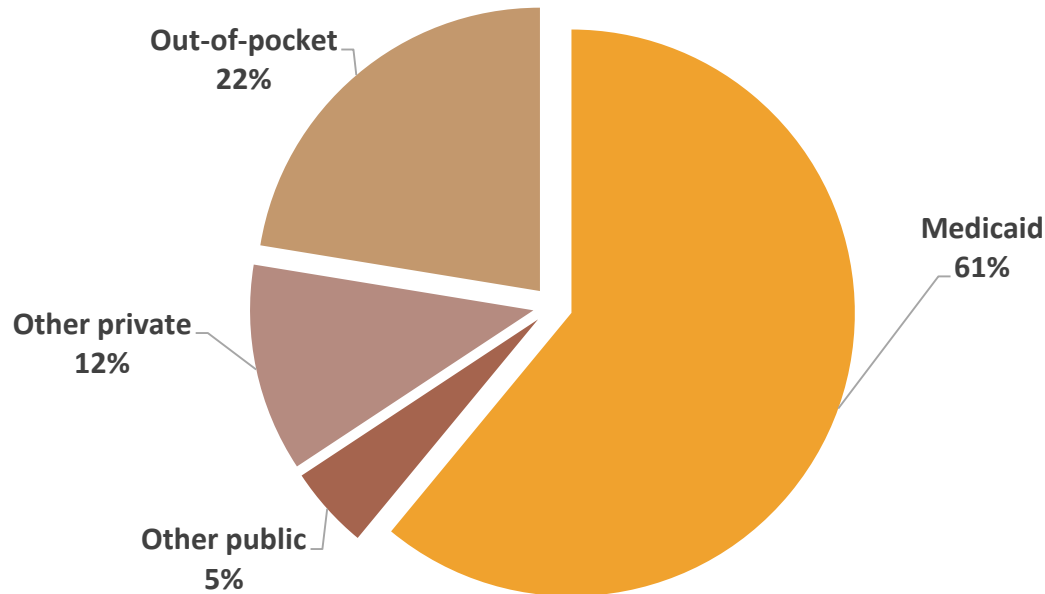
- LTSS programs are funded through both public and private funds.
  - Public sources of funds include Medicaid and Older Americans Act. Medicare funds play a much smaller role in LTSS funding, funding only “medically necessary” treatments.
  - Private sources of funds include private insurance, including long-term care insurance, and out of pocket spending.
- **Status:** Most spending on LTSS in Connecticut continues to be from public funds, as is the case at the national level. This will increase the budget impact of the larger population needing LTSS.

Payment source for institutional care in CT	1995	2014
Medicaid	68%	70%
Medicare	11%	16%
Private pay	20%	9%
Insurance	2%	1%
Other	<1%	2%

Source: CT 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. Data in table sourced from: CT Nursing Facility Registry and Annual Nursing Facility Census, OPM.

# Most U.S. LTSS Spending from Public Funds

U.S. LTSS expenditures by source of funds, 2012



Source: National Health Policy Forum, George Washington University. "The Basics: National Spending for Long-Term Services and Supports (LTSS), 2012." page 3.

# Section 4: Update on Previous Recommendations

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# Provide Strong Leadership

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- The previous CT21 report called for the Governor to make LTSS a priority
  - Included four potential implementation approaches to program management and funding
- The previous report also urged leadership by the legislature on LTSS issues
- Status:
  - Implementation of new programs (e.g., Community First Choice, Livable Communities Initiative) and additional new funding for LTSS
  - Establishment of CT Department on Aging
  - Periodic updates to state strategic plan
- However, continued state budget deficits put LTSS programs at risk, including:
  - Enacted or planned budget reductions for Medicaid reimbursements, which may affect LTSS programs
  - Increased co-pays for some LTSS programs, which may restrict access for those who most need the services

# Create a Strategy and Align the Long-Term Care System

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- The previous CT21 report called for development and implementation of a long-term care strategy.
  - Four key elements were identified: organizational structure; clearly defined goals; process and technology; and measurement and accountability
- Status:
  - In 2013, the state produced a Strategic Rebalancing Plan to guide its services in 2013 to 2015. It included utilization and cost projection models as well as strategies for rebalancing.
    - Of the 4 key elements that the previous CT21 report identified for inclusion, only the organizational structure was not significantly discussed in the 2013 strategic plan.
  - The state is in the process of updating the Strategic Rebalancing Plan for 2016 onward.
  - The Connecticut Long-Term Care Planning Committee also provided reports in 2013 and 2016 to the General Assembly on the state's LTSS system. These reports focused on the status of the state's system and offered recommendations to increase the proportion of clients receiving services via HCBS rather than in institutional care.



# Consolidate and Integrate State Long-Term Care Functions

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- The previous CT21 report called for the establishment of a consolidated, efficient all-ages human services approach to long-term care in Connecticut that maximizes the impact of Medicaid dollars and Older Americans act funds rather than dividing them up.
- Status:
  - The state's LTSS system is still fractured among different agencies.
    - DSS is responsible for many LTSS programs, because most LTSS is funded through Medicaid.
    - OPM manages the state's long-term care insurance partnership.
    - Both the Commission on Aging and UConn provide accountability and evaluation of services.
    - The departments of Aging, Mental Health and Addiction Services, and Developmental Services provide assistance to specific LTSS client groups.
    - Other departments (e.g., Housing, Transportation, Children and Families, and Economic and Community Development) also provide assistance to LTSS clients or providers.

# Expand ADRC and MFP Pilots

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- Status: The state has expanded both programs.
  - Aging and Disability Resource Centers (ADRCs):
    - Connecticut received three federal grants in 2010.
    - There are 12 ADRC sites across the state, which are called “Community Choices.”
  - Money Follows the Person (MFP):
    - Over 2,600 Connecticut residents have transitioned from institutional care to HCBS through the MFP program.
- Source: UConn Health, Center on Aging. “CT Money Follows the Person Quarterly Report: Quarter 3, 2015: July 1, 2015-September 30, 2015.”
- As discussed earlier, the state has expanded the MFP program and plans to continue the provision of those services after federal MFP funding ends.

# Aggressively Seek Federal Grants

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- Status: The state has been successful in pursuing additional federal funding for LTSS. New programs utilizing this federal funding include:
  - Community First Choice
  - Balancing Incentive Program
  - Testing Experience and Functional Tools Grant
  - Aging & Disability Resource Centers

# Simplify Connecticut's Medicaid Structure

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- The previous CT21 report called for parity by level of need rather than age or disability type for Medicaid-funded LTSS clients.
- Status: The state's Medicaid program continues to have diverse eligibility requirements for and services available in LTSS programs.
  - The state has made progress in simplifying enrollment in these programs, with a single prescreening application (ConneCT, [www.connect.ct.gov](http://www.connect.ct.gov)) for state Medicaid services, including LTSS. However, there are still separate applications for LTSS programs.
  - Of special note are the so-called “dual eligibles,” who are people that receive both Medicaid and Medicare.
  - One challenge in establishing parity among Medicaid LTSS programs is the federal rules for eligibility and services that guide the programs.

# Create Statewide Single Point of Entry or No Wrong Door Program

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- The previous CT21 report recommended this single point of entry would be for LTSS clients of all ages as well as their caregivers.
  - Status: The state launched MyPlaceCT.org in 2013.
    - It was designed as an LTSS information portal to accompany the launch of the state's online insurance marketplace.
    - The service also includes a call center through the 211 system.
    - Plans for the state's single point of entry system include an automated prescreening and assessment tool to help direct potential clients to services and an online dashboard for LTSS clients.
- Source: Susan C. Reinhard, Kathleen Ujavari, and Leslie Hendrickson. "State Long-Term Services and Supports Scorecard: How One State Improved." AARP Public Policy Institute, June 2015.
- As noted on the previous slide, the state also launched a single prescreening application (ConneCT, [www.connect.ct.gov](http://www.connect.ct.gov)) for state Medicaid services, including LTSS.

# Section 5: Revised Recommendations

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*These recommendations are based on the progress the state has made and the changing landscape at both the federal and state levels.*

# Establish LTSS Coordinator

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- Recommendation: One agency or individual in state government should be formally tasked with LTSS coordination.
- Rationale: Responsibilities for LTSS programming now spread across many state agencies, including but not limited to:
  - Department of Social Services
  - Office of Policy and Management
  - Department on Aging
  - Department of Mental Health and Addiction Services
  - Department of Developmental Services
  - Department of Housing
  - Department of Transportation
  - Department of Children and Families
  - Department of Economic and Community Development
  - University of Connecticut
- One point of responsibility would continue effort to break down program silos and align program details (e.g., eligibility determinations) or planning efforts (e.g., planning for transportation and housing). In long-run, may even result in savings for state, as duplication and redundancies decreased.
- Many of the following recommendations would fall under this coordinator's purview.

# Broaden Scope of LTSS Planning

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- Recommendation: Ensure LTSS planning incorporates related policy domains, such as transportation, housing, and other infrastructure.
- State is already moving forward with this, e.g.:
  - DOT recognizes needs of diverse users (including ages and abilities) as part of Complete Streets (Oct. 2014)
  - CT Department on Housing established July 2013 to coordinate all state housing programs
  - But this should be an explicit part of state LTSS planning.
- Rationale: There are many aspects of public services that need to be modified to accommodate the growing needs of an aging population and that would allow that population to “age in place,” or limit reliance on institutional care. This would also increase the potential for effective transitions from institutional care to HCBS. Examples of such services are:
  - Safer road design for an aging population, including pedestrians
  - Expansion of the public transportation system for those who cannot or choose not to drive (especially providing transit “through the door,” not “to the door”)
  - Services and additional funds to assist in retrofitting homes or building accessible housing to meet LTSS recipients’ needs
  - Investment in computer and adaptive technologies that make available or use of telemedicine or telemonitoring in place of in-person visits or assessments



# Develop Plan for Increasing Size of LTSS Workforce

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- Recommendation: The state needs to develop a comprehensive plan that balances needs of service recipients, concerns of service providers (e.g., risk, flexibility), and paid care giver needs (e.g., wages, advancement) to meet increasing needs for LTSS.
- Rationale: 1) Projected demand for LTSS-related occupations will continue growing as population ages. 2) Self-employed or contractor caregivers do not have access to workers compensation, unemployment insurance, Social Security, etc. 3) Wages tend to be lower for home care positions than for positions in institutional care.
- State strategic plan includes funds for creating 13,700 additional positions and retraining 3,000 institutional employees for HCBS. Additional funds available for workforce development.

Source: CT 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

- But this will not meet the need for LTSS workforce (see next slide)
- May include support for formalizing positions through incentives such as:
  - Outlining career path for those who want that option
  - Increasing post-hire training options to increase skills or services provided

# LTSS Workforce Demand

Occupational Title	Employment – 2010 (Actual)	Employment – 2020 (Projected)	% Change
Personal Care Aides	15,794	24,162	53.0%
Home Health Aides	10,533	14,343	36.3%
Registered Nurses	37,404	44,550	19.1%
Nursing Aides, Orderlies, Attendants	13,304	25,848	10.9%
Occupational Therapists	1,967	2,342	19.1%
Occupational Therapist Assistants	616	813	32.0%
Physical Therapists	3,748	4,538	21.1%
Physical Therapist Aides	555	703	26.7%
Physical Therapist Assistants	436	562	28.9%
Respiratory Therapists	1,360	1,678	23.4%
Speech Language Pathologists	1,736	1,999	15.1%

Source: CT 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. Data sourced from: Office of Policy Management and Department of Labor, Connecticut Statewide Forecast: 2010-2020

# Expand LTSS-HCBS Awareness Campaign

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- Recommendation: LTSS Coordinator should implement a comprehensive awareness campaign to increase understanding and uptake of HCBS, rather than institutional, services.
- Rationale: The state ran a marketing campaign as part of MFP, but it was primarily focused on hospital and doctor awareness of HCBS as an alternative to institutional care for LTSS. This effort should be extended to LTSS recipients and their care givers so they fully understand options available – including new programs, such as Community First Choice – and to reduce the bias toward institutional care.
  - One interviewee: “[The] structure is done. Now a shift in community’s way of thinking is needed.”
- This could enhance or utilize MyPlaceCT.org, the state’s single point of entry for LTSS.

# Continue Process of Restructuring Provider Reimbursement Rates

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- Recommendation: DSS has begun the process for restructuring Medicaid reimbursements to institutional LTSS providers. It should continue this process to reflect changing service patterns under MFP.
- Rationale: The current service reimbursement structure for LTSS care is inconsistent and based on many factors. It also has not been adjusted to reflect that institutional providers may be dealing with higher acuity patients since rebalancing initiatives have moved those with lower acuity needs into HCBS care.
- Factors to consider for inclusion in restructured rates:
  - Acuity-based reimbursements
  - Geographic adjustment factors
- Rate adjustments can be phased in to limit effect on providers and communities. Reimbursement rates could continue to incorporate some cost reimbursement (e.g., due to age of building).

# Develop Single Source of Data

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- Recommendation: Develop a single metric for LTSS need to allow for consistent collection of data and evaluation of programs
- Rationale: Currently many sources of data on those potentially needing LTSS and no single definition of disability or LTSS need
  - Generally, disability is used as proxy for LTSS need, but not everyone with a disability needs LTSS
  - Some sources: American Community Survey; CDC Behavioral Risk Factor Surveillance System surveys

Source: CT 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

# Section 6: Best Practices

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# Oregon

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- Oregon ranks:

- 1st nationally on percentage of LTSS Medicaid expenditures spent in HCBS setting (versus institutional care)
- 4th nationally on LTSS Medicaid expenditures per resident

Source: Truven Health Analytics. "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending." June 30, 2015.

- Select program highlights:

- Coordinated Care Organizations (CCOs)
  - Supported by global Medicaid budget and have fixed trend rate and incentives for performance goals
  - Required to create Alternate Payment Methods for providers and implement strategies according to community needs
  - Provides flexible services with clinical/non-clinical and non-traditional healthcare workers that range from housing improvements to social services
  - Offers risk and gain-sharing plans with providers and incentive matrices for agents and healthcare practitioners
- State Innovation Model implemented in 2012 with three year testing period
  - Oregon Transformation Center has centralized network for payers, providers, community stakeholders, and consumers using data and analytics to improve management and providing technical support for alternate payment methods
  - Innovator Agents assigned to each CCO as point of contact between CCO and Oregon Health Authority and to provide data-driven feedback on strategic impact
  - Learning Collaboratives spread and accelerate implementation of best practices
- Acknowledges the importance of Health Care Interpreters (HCIs) and non-traditional healthcare workers (NTHW) who:
  - Integrated with CCO team as equal partners in service delivery model
  - Recruits and trains HCIs and NTHWs, with goals to train 300 new community health workers by 2015 and 150 HCIs by 2016
- Technical assistance to ensure effective use and access to innovative person-centered care
  - Includes Electronic health record (EHR) expansion, mobile devices, home monitoring tools, and tele-health technology

Sources: Oregon Health Authority. "Project Narrative: Oregon State Innovation Models Testing Assistance Application." September 2012. Anna Spencer, James Lloyd, and Tricia McGinnis. "Using Medicaid Resources to Pay for Health-Related Supportive Services: Early Lessons." Center for Health Care Strategies Brief. December 2015.

# Minnesota

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- Minnesota ranks:

- 2<sup>nd</sup> nationally on percentage of LTSS Medicaid expenditures spent in HCBS setting (versus institutional care)

*Source: Truven Health Analytics. "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending." June 30, 2015.*

- 1<sup>st</sup> on AARP/Commonwealth Fund/Scan Foundation State Scorecard on LTSS

- Select program highlights:

- Focused on long-term policy planning (e.g., *Aging 2030* framework)
  - LTSS provided in managed care setting – mandatory plan selection by most program clients age 65 or older
  - “Rate equalization” – nursing homes cannot charge private-pay residents more than Medicaid reimbursement rate for those in a shared room
    - Only 1 of 2 states to offer this
  - Alternative Care Program – those who do not meet Medicaid income/assets rules for extended nursing home admission pay costs based on sliding scale
  - Prospective residents of “housing with services” must call Senior LinkAge for information about LTSS
    - Prior voluntary program saw 50% of those who called choosing to remain at home instead of entering housing
  - Pay-for-performance program for nursing homes to improve quality of life/care
    - Data show improvement in quality of life/care compared to non-participating nursing homes
  - Long-term care consultative service – assists clients in LTSS decision-making. Includes social worker and public health nurse, who visit clients no more than 15 days after request for assessment
    - Also developing an internet-based, multiple program assessment tool
  - Care coordination includes: case management for those on waivers but also health care access and monitoring
  - Programs to support employment of those with physical disabilities

*Sources: Robert Mollica and Leslie Hendrickson. 2012. "State Long-Term Services and Supports Scorecard What Distinguishes High- from Low-Ranking States? Case Study: Minnesota." AARP. Ujvari, Kathleen, Wendy Fox-Grage, and Leslie Hendrickson. 2015. "Effective Transitions between Care Settings." AARP Public Policy Institute.*



# Washington

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- Washington ranks:

- 6<sup>th</sup> nationally on percentage of LTSS Medicaid expenditures spent in HCBS setting (versus institutional care)

*Source: Truven Health Analytics. "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending." June 30, 2015.*

- 2<sup>nd</sup> on AARP/Commonwealth Fund/Scan Foundation State Scorecard on LTSS

- Select program highlights:

- Legislation passed in 1993 to emphasize HCBS and, consequently, reduce number of nursing home beds
  - Caseload Forecast Council
    - Develops monthly forecasts of all entitlement caseloads, which allows strategic planning
  - Interdisciplinary Care Teams
    - Health Home Program managers are cross-trained in determinants of health; integration specialists cross-trained in chronic disease impact; case managers are trained in skill building and support
    - Community based care management increases team member direct contact with enrollees and ensures outreach to vulnerable populations
  - Risk modelling across programs
    - Isolates cost drivers and models the effect of program costs on overall system to assist the state in making cost-effective investments on a program by program basis.
  - Has targeted some transition efforts to individuals with mental illness
  - MFP Tribal Initiative
    - Empowers the community to care for its elders and expand capacity of Medicaid in tribal areas with more local input

*Sources: Leslie Hendrickson and Laurel Mildred. "Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home and Community Based Services; Recommendations for California." January 2012. Kaiser Family Foundation. "Roads to Community Living: A Closer Look at Washington State's Money Follows the Person Demonstration." February 2013.*

# New Jersey

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- New Jersey ranks:
  - 2nd in effective transitions for people with intellectual disabilities

*Noelle Denny-Brown, et al. "The Right Supports at the Right Time: How Money Follows the Person Programs Are Supporting Diverse Populations in the Community." Mathematica Policy Research, April 2015.*

- Select program highlights:
  - Services provided through MLTSS (managed long term supports and services)
    - Individuals in 4 Medicaid waiver programs automatically transitioned to MLTSS system on July 1, 2014, and those newly eligible after that date automatically added
    - Options Counseling is available for potential applicants through ARDCs or Division of Disability Services to discuss current needs and potential services
    - Scheduled conference calls with managed care organizations for first year of program. Also solicits feedback from providers and consumers
  - Incorporated the local initiative "I Choose Home" into the 2008 MFP program – Allowed flexible funding for individualized and specialized care with intensive support and monitoring for the initial 90 days of the transition
  - Personal Preference Program – Based on "Cash and Counseling" program, clients select own caregivers, who are paid with funds that otherwise would have been used for services for those clients
  - Incident response and quality assurance monitoring
    - Duties include monitoring provision of services, administering Quality of Life surveys, and collecting and analyzing data in 30-day increments until issues are resolved
    - Crisis response team evaluates safety risk preemptively, evaluates safety risks, and implements strategies to monitor progress. Also offers technical training to reduce risk of incidents and re-institutionalization and follows up on failed transitions
  - Interdepartmental collaboration of stakeholders at state and local levels
  - Rebalanced MFP funds to cover capital costs of acquiring or rehabilitating four-bedroom group homes to increase transitions from developmental centers

*Sources: Lowell Arye, "MLTSS and Community Providers: New Jersey's Experience." Presentation to the National Academy of State Health Policy Conference, October 20, 2015. Noelle Denny-Brown, et al. "The Right Supports at the Right Time: How Money Follows the Person Programs Are Supporting Diverse Populations in the Community." Mathematica Policy Research, April 2015.*

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