

Connecticut Medicaid

Rebalancing of Long-Term Services & Supports

Department of Social Services

What is Rebalancing?

Rebalancing refers to reducing reliance on institutional care and expanding access to community Long-Term Services and Supports (LTSS). A rebalanced LTSS system gives Medicaid beneficiaries greater choice in where they live and from whom they receive services. It also delivers LTSS that are integrated, effective, efficient, and person-centered. Achieving a rebalanced LTSS system requires that states examine current policies, services, access, and other systemic elements that may present challenges to rebalancing goals. In January, 2013, the Governor, the Office of Policy and Management and the Department of Social Services

released the State's Strategic Plan to Rebalance LTSS. This plan details diverse elements of a broad agenda that is designed to support older adults, people with disabilities and caregivers in choice of their preferred means, mode and place in which to receive LTSS. Key aspects of the plan include 1) continued support for Money Follows the Person; 2) State Balancing Incentive Payments Program (BIPP) activities; 3) nursing home diversification; and 4) launch of a web-based hub called "My Place". The strategic plan also identifies 'hot spots' for development of services, including medical services, by projecting demand attributed to the aging population at a town level. Consistent with the Supreme Court's decision in *Olmstead*, the rebalancing plan supports provision of services in the most integrated setting that is appropriate for each individual.

Why Are We Focusing Here?

Consumers overwhelmingly wish to have meaningful choice in how they receive needed long-term services and supports. Connecticut's Medicaid spending remains weighted towards institutional settings, but re-balancing is shifting this. In SFY'14, a total of \$1.934 billion was spent in Connecticut on LTSS. This represented 11% of the state budget and 37% of the Medicaid budget. In SFY'14, 61% of beneficiaries of Medicaid LTSS received those supports in the community, but 29% of LTSS spending was attributable to these services.

Key Strategies:

The Department of Social Services Division of Health Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. Strategies include:

- 1) use of an administrative services organization (ASO) to promote efficient, cost-effective and consumer/provider responsive Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services;
- 2) use of data analytics to improve care;
- 3) activities in support of improving access to preventative primary care;
- 4) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS);
- 5) initiatives designed to "re-balance" spending on LTSS; and
- 6) efforts to promote the use of health information technology.

Looking for information on LTSS?

Access MyPlace CT at the following link:

<http://www.myplacect.org/>



What Do We Mean by Person-Centered Care?

We define person-centeredness as an approach that:

- provides the individual with needed information, education and support required to make fully informed decisions about his or her care options and, to actively participate in his or her self-care and care planning;
- supports the individual, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and
- reflects care coordination under the direction of and in partnership with the individual and his/her representative(s); that is consistent with his or her personal preferences, choices and strengths; and that is implemented in the most integrated setting.

Re-balancing is an overarching agenda that has as its main goals enabling choice for consumers, optimizing use of public spending on long-term services and supports, and diversification of provider services.

Connecticut Medicaid Key Strategies

- **Money Follows the Person.** The Money Follows the Person (MFP) initiative has led efforts toward systems change in LTSS. In addition to having transitioned over 3,000 individuals from nursing facilities to the community, MFP is implementing diverse strategies that support reform. Key MFP demonstration services include: care planning specialized in engagement and motivation strategies, alcohol and substance abuse intervention, peer support, informal caregiver support, assistive technology, fall prevention, recovery assistance, housing coordination, self-directed transitional budgets including housing set-up, transportation assistance and housing modifications. Systems focus areas for MFP include housing development, workforce development, LTSS service and systems gap analysis/recommendations and hospital discharge planning interventions.
- **State Balancing Incentive Payments Program (BIP).** MFP has also led efforts to submit an application to CMS under the BIP. Connecticut received confirmation in Fall, 2012 of a \$72.8 m. award. In July 2015, Connecticut received an additional performance-related award of \$4.2 m. Key aspects of the BIP awards include development and implementation of:
 - a pre-screen and a common comprehensive assessment for all persons entering the LTSS system;
 - conflict-free case management across the system;
 - a 'no-wrong door' system for access to LTSS – this web-based platform was branded "My Place CT" and aims to coordinate seamlessly with both ConneCT and the health insurance exchange; and
 - new LTSS aimed to address gaps that prevent people from moving to or remaining in the community, streamline the existing LTSS delivery system, and build a sufficient supply of services to address the projected demand.
- **Community First Choice (CFC).** Launched in July, 2015, CFC will enable Medicaid beneficiaries who require nursing facility or other institutional level of care to self-direct community-based services under individual budgets, with the support of a fiscal intermediary. Services include (as applicable) support for costs of transitioning from institutions to the community as well as services that increase independence or substitute for human assistance (personal care assistants, support and planning coach, nurse coach, home delivered meals, environmental accessibility modifications, Personal Emergency Response System (PERS), and assistive technology).

Connecticut Medicaid Key Strategies (cont.)

- **Nursing Home Diversification.** Another important feature of rebalancing is \$40 million in grant and bond funds through SFY 2017 that has been dedicated to nursing facilities that are interested in diversifying their scope to include home and community-based services. Supporting selection of facilities through a Request for Proposals process are town-level projections of need for LTSS and associated workforce, and a requirement that applicant nursing facilities work collaboratively with the town in which they are located.
- **Waiver services.** Connecticut is continuing to expand the scope of its Medicaid “waiver” coverage. “Waivers” permit the state to be excused from certain federal Medicaid rules and to cover home and community-based long-term services and supports using Medicaid funds. Existing waivers enable services to older adults, individuals with physical disabilities, individuals with behavioral health conditions, children with complex medical profiles, individuals with intellectual disabilities, children with autism spectrum disorder (ASD) and individuals with acquired brain injury (ABI). Recent activity has included expansion of the array of waivers that is available to people with intellectual disabilities, as well as creation of a small waiver to support children with ASD who are aging out of the Birth to Three program.
- **Preadmission Screening.** The Department utilizes a web-based system for the federally mandated Preadmission Screening Resident Review (PASRR) program. The system identifies persons who are in need of both long-term and short-term institutional care, and recommends alternatives to those whose preference is for home and community-based services options.

How Are We Doing?

- **MFP transitions:** In SFY’15, MFP transitioned 704 individuals from nursing facilities to community-based settings. Since its inception in December, 2008, MFP has transitioned over 3,000 individuals from nursing facilities to community-based settings, towards an ultimate goal of 5,000.
- **Nursing home diversification:** In early 2014, the administration awarded \$9 million in grant funds to seven entities. In May, an additional four homes received grant funds. The Department will release another Request for Proposals in October, 2015 with available funding in the amount of \$25 m.
- **BIPP:** Diverse efforts are underway to streamline and standardize access to LTSS across the state within the structure of the Department’s replacement Eligibility Management System (EMS), which will be called Impact:
 - in support of the Core Standardized Assessment (CSA), all involved agencies have agreed to implement a standardized assessment across programs, supporting the State’s goal of linking standard levels of needs to standard budget allocations;
 - in support of streamlined intake processes (No Wrong Door), DSS drafted and submitted an Advanced Planning Document outlining the funding and information technology architecture required to support standardization of functional eligibility processes and assessments across LTSS programs.
- **System Transformation:**
 - Increased, for those in need of LTSS, the percentage of hospital discharges to home and community care rather than nursing facility care – from 47% in 2007 to 53% in 2014.
 - Increased the percentage of LTSS expenditures to home and community rather than nursing home care - from 33% in 2007 to 45% in 2014.
 - Increased the percentage of nursing facility admissions returning to the community within six months of admission - from 30% in 2007 to 36% in 2014.
 - Increased the percentage of people receiving LTSS in the community versus in institutions – from 52% in 2007 to 59% in 2014.

Meet a Beneficiary:

"Great . . . Laugh . . . Alive . . . Blessed"

Ms. C's four words describe her thriving experience at home under MFP after ten years in a nursing facility. She glows as she talks of her connections and re-connections with family and friends. Although a stroke limits her speech, hearing and use of part of her body, she overcomes communication and mobility issues in creative ways. A whiteboard and laptop are her constant companions to express thoughts and feelings, and for visitors to utilize when conversations are not heard adequately or get complicated. This process enables Isabelle to socialize; visiting as well as receiving family, friends and neighbors at her home and "chatting across the table like a normal home activity".

Loving children and their playfulness, she is grateful she lives in a large community where many of her neighbors are families. Most days, she is outside in the quad area watching the children play. A lifelong lover of music, she is delighted to make friends with a young neighbor who routinely comes to play her instrument for her. Feeling the freedom of home, Isabelle practices her spiritual life. Her faith is very important to her, as expressed in her surroundings and her own sacred latch-hooked rugs. She feels blessed and spiritually connected by the weekly visits she has with a Eucharistic minister from her church.

Connecting with nature is very important. Previously an avid camper, Isabelle finds time every day to fill her bird feeders on her patio and observe the birds' behaviors. Weather doesn't stop her; she loves to feel the seasons. In her wheelchair, she and her aide take almost daily walks to the pond and picnic tables to scout out and observe the wildlife, especially the great blue heron, as well as the flowers and country scenery. Dogs are a personal favorite, and she visits with therapy dogs at Hartford Hospital as well as a nearby Yorkie Rescue House.

Although there is always more therapy to do, she now uses one hand and arm to pursue bowling and other occupational therapy activities. A life-long crafter and knitter, she is working hard to adapt to using one hand and now paints colorful sun-catchers, ornaments and other art. An expert Scrabble player, she also participates in indoor and outdoor games to keep her mind and body alert.

What Impact has this had for the People Served?

We have:

- increased the percentage of people who are happy with the way they live their lives - from 62% while institutionalized to 78% after move to the community;
- increased the percentage of people who report that that are doing fun things in their communities - from 43% while institutionalized to 59% after move to the community; and
- increased the percentage of people report that they are being treated the way in which they wish to be - from 83% while institutionalized to 94% after move to the community.