Testimony before the Legislative Program Review and Investigations Committee
Department of Social Services
September 21, 2016

Good morning Senator Fonfara, Representative Carpino and members of the Legislative Program Review and Investigations Committee. Our names are Kathy Bruni, Director of the Community Options Unit Operations Team and Dawn Lambert, Manager of the Community Options Unit Strategy Team.

Thank you for the invitation to participate in the Legislative Program Review and Investigations Committee (PRI) public hearing on factors influencing receipt of long-term care services and supports in home and community-based settings study. As you may know, this subject is a primary area of strategic focus for the Department of Social Services, Division of Health Services. Related goals, strategies and tactics are detailed within the Governor's Strategic Rebalancing Plan for Long-Term Services and Supports. Primarily funded through federal grants, the Department is in its 4th year of plan implementation.

Foundational programs underlying the implementation of the plan are the Connecticut Home Care Program and the Money Follows the Person Demonstration. Together, these programs provide Connecticut citizens with access to services and supports in the community. Diversion and transitional activities from institutional settings are key elements of our strategic plan.

In partnership with the University of Connecticut Center on Aging, the Department maintains a focus on research and data related to measuring outcomes, understanding challenges, and implementing change. Together, we work towards a long-term services and supports system that demonstrates continual improvement. Additionally, we learn from other states – Connecticut is part of a national collaborative that meets several times a month to share new innovations and discuss strategies moving forward.

Attached to this summary we have prepared comments in the format of a power point presentation to highlight progress aligned with the Committee's investigation. We look forward to working with the Committee on this important subject.

Connecticut HUSKY Health:

Strategic Rebalancing Plan for Long-Term Services and Supports:

Increasing Efficiency and Reducing Cost

Department of Social Services

Public Comment

Wednesday, September 21, 2016

The Governor's Strategic Rebalancing Plan for Long-Term Services and Supports

What is "rebalancing"?

Rebalancing refers to reducing reliance on institutional care and **expanding access to community-based 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**.

Why rebalance the system?

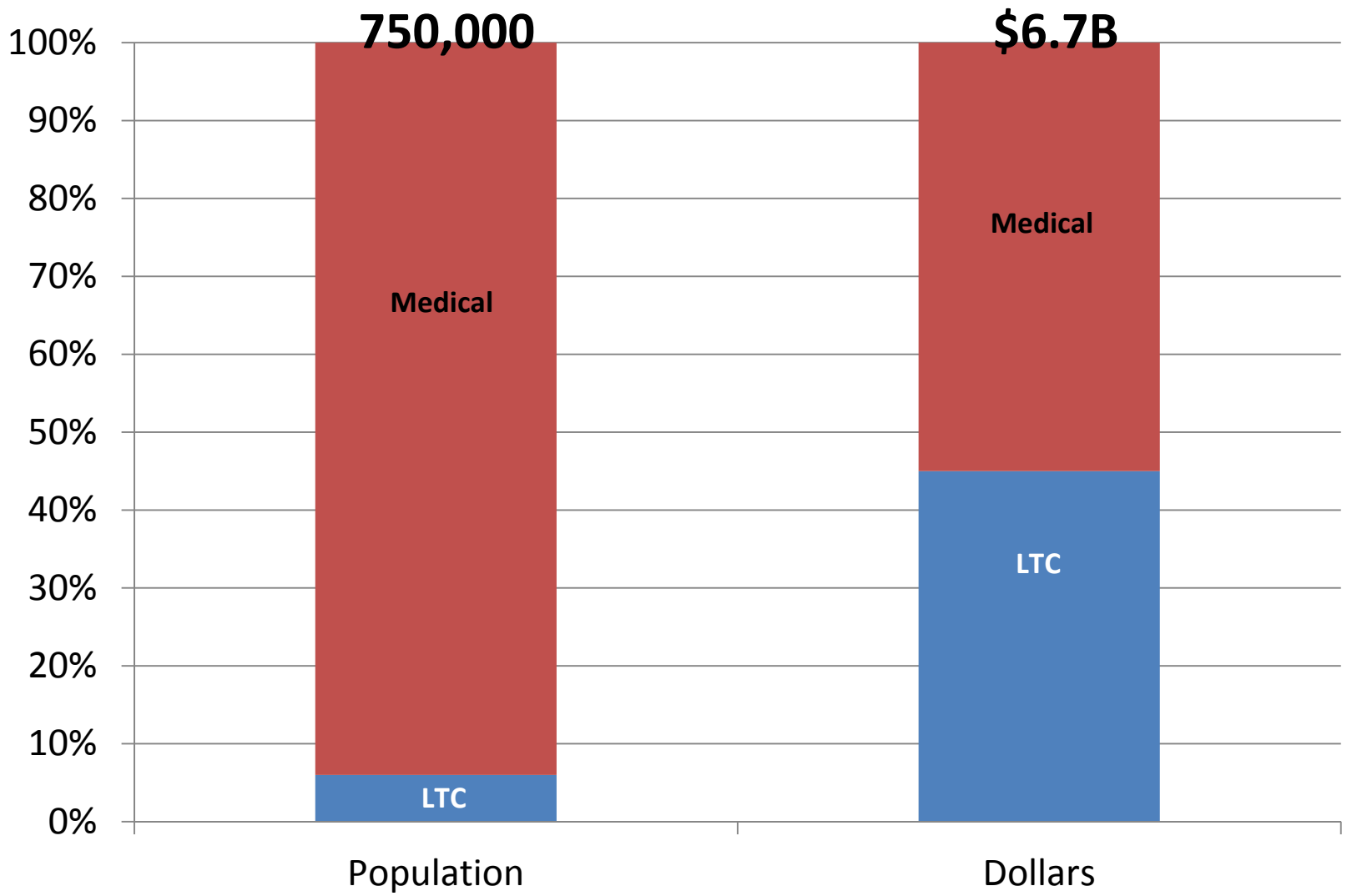
- **Consumers overwhelmingly wish to have meaningful choice** in how they receive needed LTSS.

- In Olmstead v. L.C. (1999), the Supreme Court held that Title II prohibits the unjustified segregation of individuals with disabilities. **Medicaid must administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.**

Why rebalance the system? (cont.)

- A relatively small number of individuals use LTSS, but their **costs are a significant proportion of the Medicaid budget**.
- Individuals who use LTSS typically have **high needs and high costs** and **benefit from coordination** of their services and supports
- Average per member per month **costs are less in the community**.

Background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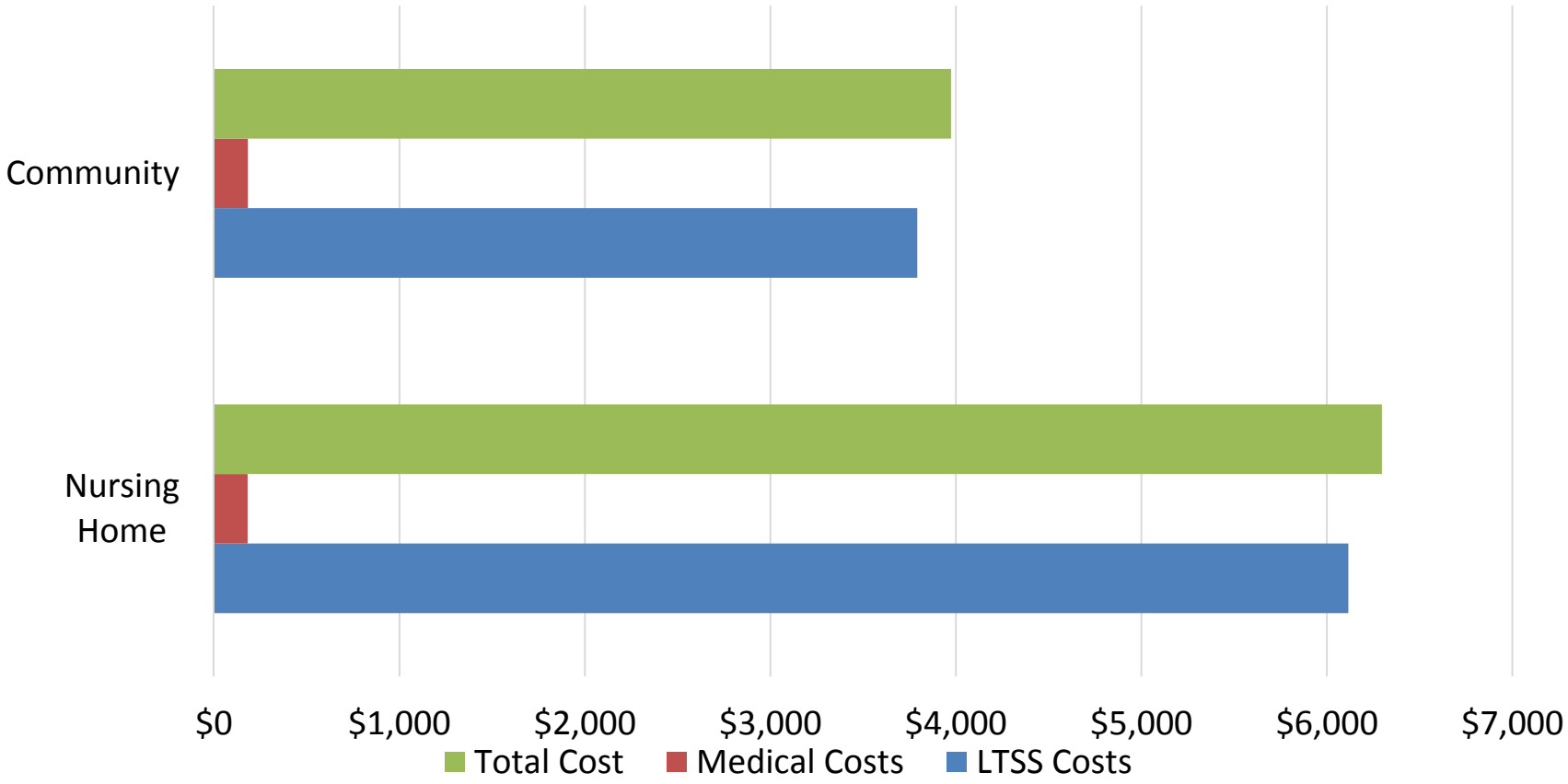
Background (cont.)

A comparison of average community and institutional costs for individuals at nursing home level of care (2012)



Why rebalance the system? (cont.)

- **People have historically faced barriers** in Medicaid to receiving community-based LTSS
  - lack of sufficient services, supply, and information
  - inadequate support for self-direction and person-centered planning
  - lack of housing and transportation
  - lack of a streamlined process for hospital and nursing home discharges to the community
  - lengthy process for accessing Medicaid as a payer
  - lack of a sufficient workforce

How are we rebalancing LTSS?

Rebalancing Plan

- We are guided by a **comprehensive, Governor-led, legislature-supported rebalancing plan** with these key goals:
  - ***Improve effectiveness and efficiency of*** *Connecticut's* ***Home and Community-Based Services (HCBS) system***
  - ***Decrease hospital discharges to nursing facilities*** *among those requiring care after discharge*
  - ***Transition 8,000 people from nursing homes to the community*** *by 2020*
  - ***Build capacity in the community workforce*** *sufficient to sustain rebalancing goals*
  - ***Increase availability of accessible housing*** *and transportation*
  - ***Adjust supply of institutional beds*** *and community services and supports* ***based on demand projections***

Connecticut's plan 'Strategic Rebalancing Plan: A Plan to Rebalance Long-Term Services and Supports 2013- 2015 is found at the following link: http://www.ct.gov/dss/lib/dss/pdfs/frontpage/strategic_rebalancing_plan___1_29_13_final2_(2).pdf

Rebalancing Plan

- We and our state agency partners are supported by a consumer-led, diverse, and engaged group of stakeholders:

Focus on Data

- We have an **unwavering focus on data**.
  - The University of Connecticut Center on Aging has, since inception of Connecticut rebalancing efforts, been DSS' research and evaluation partner.
  - The Center on Aging supports DSS in tracking and trending a broad range of system-wide and individual indicators – for more detail on this, please see this link:

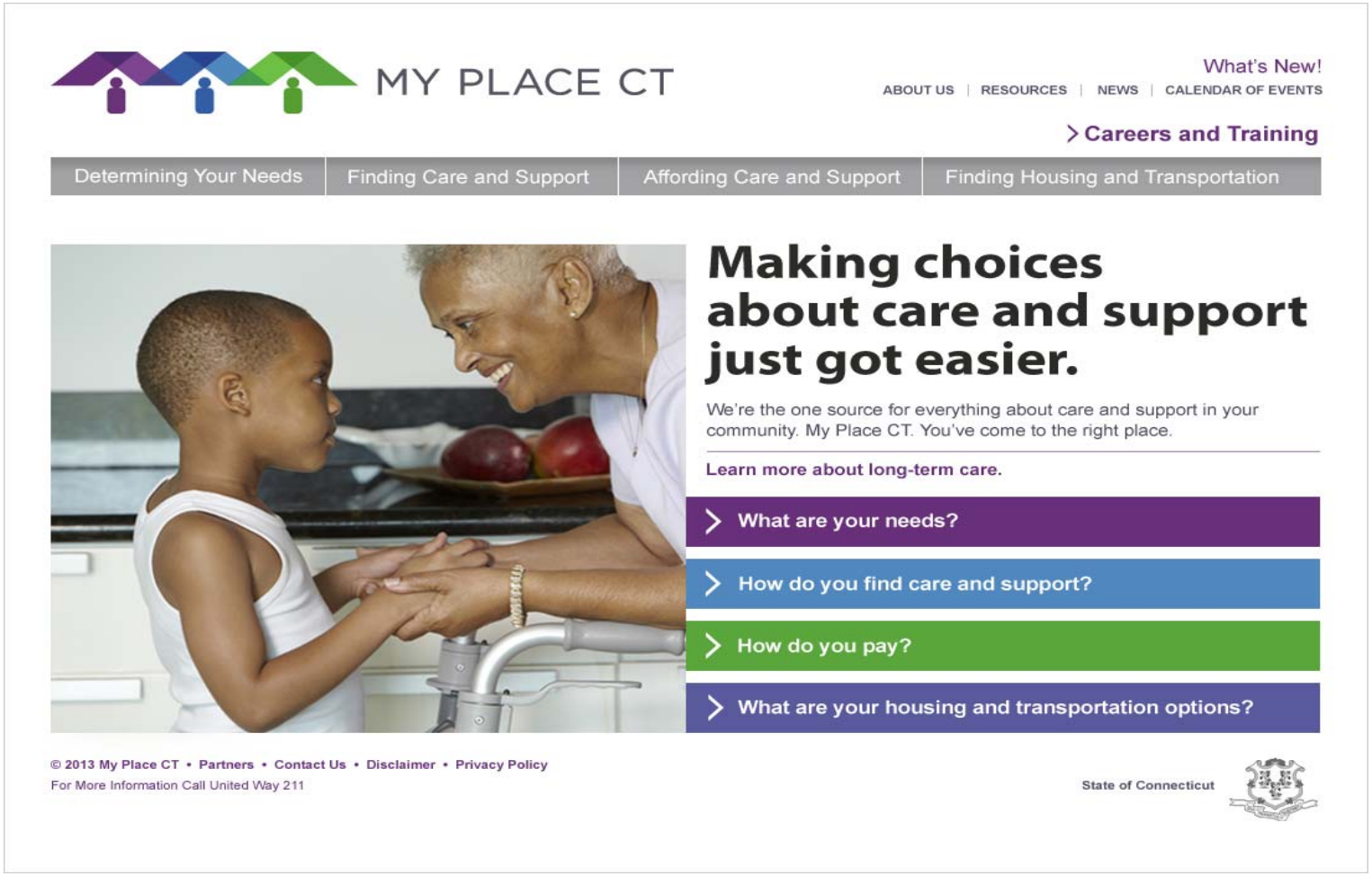
http://www.uconn-aging.uchc.edu/money_follows_the_person_demonstation_evaluation_reports.html

Access to Information

- We are giving people **access to information** that supports informed choice.
  - We have launched a comprehensive LTSS web resource called **"My Place"**: http://www.myplacect.org/.
  - We are using federal dollars to **design systems to enable access to information**, including information on eligibility, the results of functional assessments, and implementation of Personal Health Records.

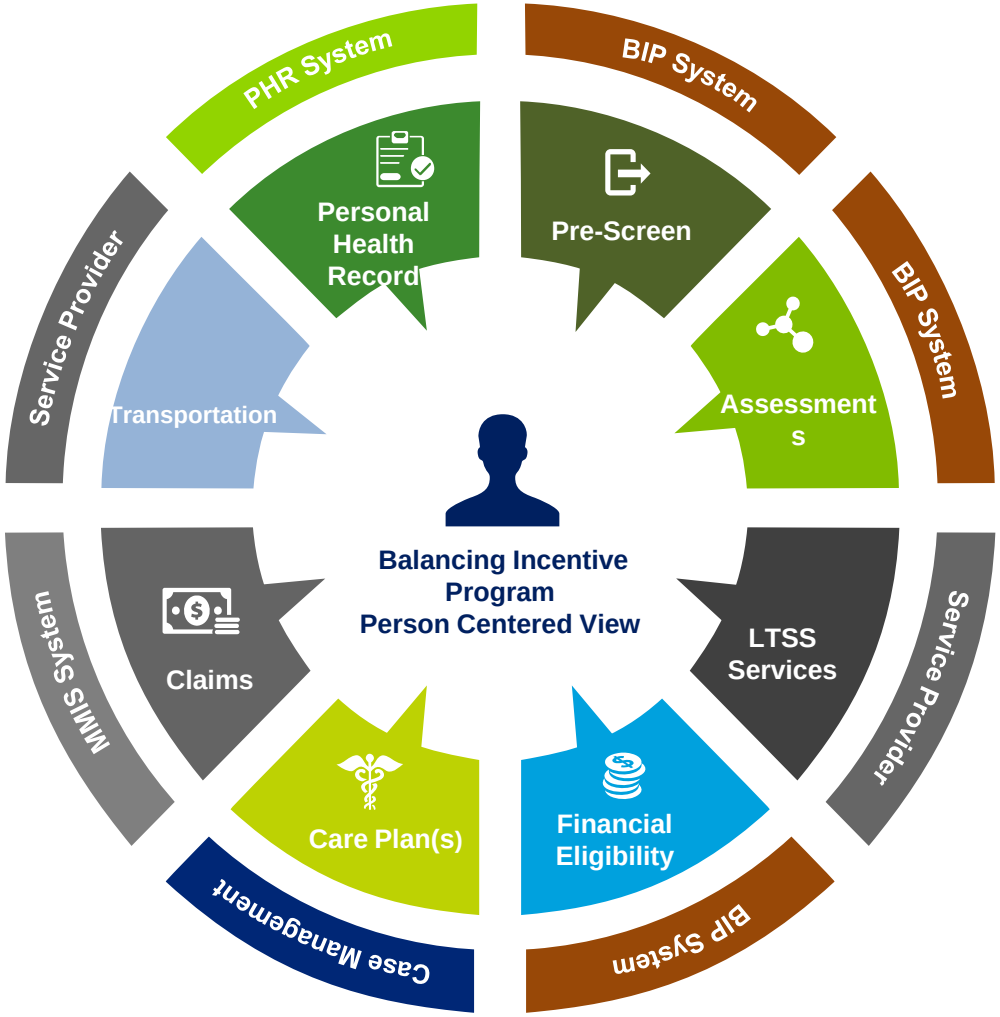
Access to Information (cont.)

My Place is an incredible resource for individuals, families and providers.



Access to Information (cont.)

The Balancing Incentive Program (BIP) is allowing us to take a **systems approach to supporting peoples' need to access and use information.**



Self-Direction

- We are **supporting self-direction**.
  - Connecticut is one of the early adopters of the ACA **Community First Choice (CFC) option**, which permits states to cover personal care assistants and other self-direction supports under the Medicaid State Plan.
  - Connecticut implemented CFC in July, 2015.

Improved Eligibility Process

- We are **streamlining the LTSS eligibility process.**
  - We have created a **dedicated HCBS eligibility processing unit** in Hartford that now handles all applications for HCBS waiver services, statewide.
  - BIP is enabling a **systems approach** to effectively integrate LTSS eligibility within the Department's project to replace its entire Eligibility Management System (EMS).

Housing

- We are **enabling access to affordable, accessible housing**.
  - Connecticut's Money Follows the Person (MFP) model is a unique **"housing plus supports" model** under which people may receive both services and housing vouchers.
  - Both MFP and Medicaid waivers also support **accessibility modifications** to housing.

Innovator Accelerator Program (IAP)

IAP is an intensive, six-month technical assistance opportunity designed to help states support individuals served by Medicaid in accessing and retaining stable housing; and meaningfully engaging with providers they choose to achieve their health goals.

Collaboration among Connecticut's:

- Department of Social Services
- Department of Housing
- Department of Mental Health and Addiction Services
- Department of Developmental Services
- Office of Policy and Management
- CT Housing Finance Authority
- Partnership for Strong Communities, and
- Corporation for Supportive Housing

Innovator Accelerator Program

IAP GOALS:

- Help states align policies and funding between state Medicaid, disability services, and housing agencies to maximize affordable and supportive housing opportunities;

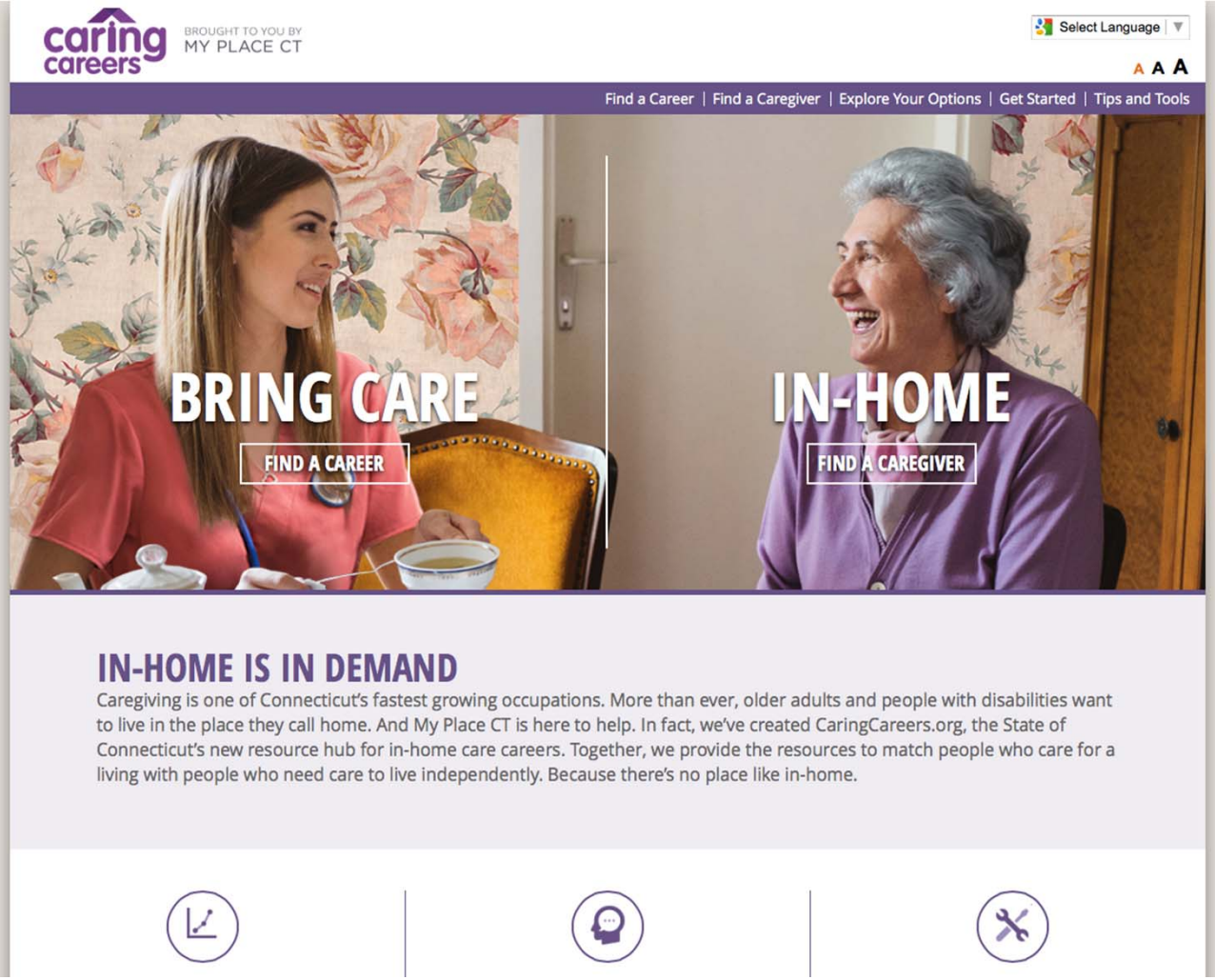
- Ensure people experiencing chronic homelessness, people identified as high utilizers of health care services, and/or individuals with disabling conditions who are exiting institutional settings have access to a service package linked to housing to improve access to health care and outcomes and reduce costs; and

- Help states take advantage of opportunities in Medicaid to cover and finance services in supportive housing while maximizing the use of other resources to pay for non-Medicaid supports.

Workforce

- We are **supporting development of an adequate community workforce.**
  - The Governor has directed bond funds and other resources to a grant process through which nursing homes have applied for and received funds for **"right-sizing"** (diversifying their services to include HCBS).
  - We are using My Place to create a **forum for direct care workers.**

Workforce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BRING CARE
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FIND A CAREGIVER
IN-HOME IS IN DEMAND
Caregiving is one of Connecticut's fastest growing occupations. More than ever, older adults and people with disabilities want to live in the place they call home. And My Place CT is here to help. In fact, we've created CaringCareers.org, the State of Connecticut's new resource hub for in-home care careers. Together, we provide the resources to match people who care for a living with people who need care to live independently. Because there's no place like in-home.

And what are our results?

CT operates 11 Medicaid Waiver Programs

- 7 Operated directly by DSS
- 3 Operated by the DDS
- 1 operated by DMHAS
- Two HCBS State Plan Options
  - 1915i effective 2012
  - 1915k effective 2015

Connecticut Home Care Program for Elders

- Currently serving 12,500 clients age 65 and over
- 2010 waiver served 12,456 unduplicated participants with 13 services
- 2014 waiver served 13,688 unduplicated participants with 20 services
- Added Services:

Personal Care Assistant, Independent Support Broker, Adult Family Living, Bill Payer, Care Transitions, Chronic Disease Self Management programs, Recovery Assistant

Information

- In 2010, utilizing funds under the Money Follow the Person Demonstration, we partnered with UCONN Center on Aging to answer the question: *'What are the unmet needs and associated service gaps for individuals who leave the program and enter a nursing home?'*
- Study follows 3 components:
  1. Review of CHCPE administrative data for a retrospective cohort of CHCPE clients
  2. Review of Care Manager notes for a 15% sample of the retrospective cohort
  3. Focus groups with Access Agency care managers to address broader aspects of systems gaps leading to nursing home admission

Study Recommendations

1. Add PCA services
2. Expand Adult Day Programs and Adult Family Living
3. Flexible Home Care Provider that can do hands on care as needed
4. Mental Health and Substance Abuse Services and Training
5. Transportation
6. Care Manager Training
7. Coordination With Hospital and Nursing Home Discharge Planning

Improved Services

- 7/1/2010- PCA service including live- in was added
- 4/1/13 –Amendment added Adult Family Living
- 7/1/15 – Care Transitions, Bill Payer, Chronic Disease Self Management and Recovery Assistant Services were added to the program
- We continually evaluate the effectiveness of the services including our survey data, info from providers, family members and waiver participants

Decreased Discharges to Nursing Homes

- Percent of discharges from Connecticut Home Care Program for Elders to nursing home placement:
- SFY 2012- 45.14%
- SFY 2013 - 41.19%
- SFY 2014 – 41.26%
- SFY 2015 - 39.13%
- SFY 2016 -37.73%

Fast Track Improved Access to Services

- FAST TRACK- An initial screening of every Medicaid application for CHCPE
- Goal: Authorize services to begin within 48 hours of receipt of the application

- Application Data:
- **2,674** Total CHCPE applications (82.3% of all applications)
- **220** Total Fast Track applications (8.3% of all CHCPE applications)

Fast Track Improved Access to Services

- **31%** of CHCPE applications were incomplete
- **16%** of CHCPE applicants were already receiving state-funded services on the state funded home care program or were already Medicaid active on another program
- **8%** of CHCPE applications were via M-2T only without an application form
- **10%** of CHCPE applicants were over the asset limit
- **6%** of CHCPE applicants were over the income limit
- **5%** of CHCPE applicants were already active Category 3
- **7%** of CHCPE applicants had no assessment at time of application
- **2%** of CHCPE applicants reported a transfer of assets
- **9%** of CHCPE applications came in via signature page only (this indicates that client was denied less than 30 days prior and is reapplying. This practice stopped in 12/2015. Applicant may or may not have received Fast Track services, were denied and now reapplying.
- **3%** of CHCPE applicants applied via interoffice application
- **3%** of CHCPE applications were online applications only

Fast Track Improved Access to Services

- **188** CHCPE applicants were granted and accepted Fast Track services. Those **91** applicants who cooperated with the application process and were found eligible for full Medicaid continued receiving the services without a gap. Those **97** applicants that did not achieve full Medicaid eligibility received services that eventually stopped after their Medicaid application was denied. In either case, it is our hope and vision that the **Fast Track services received enabled the individual to remain in their living arrangement of choice and promoted a person-centered approach to long-term services and support**.

Information

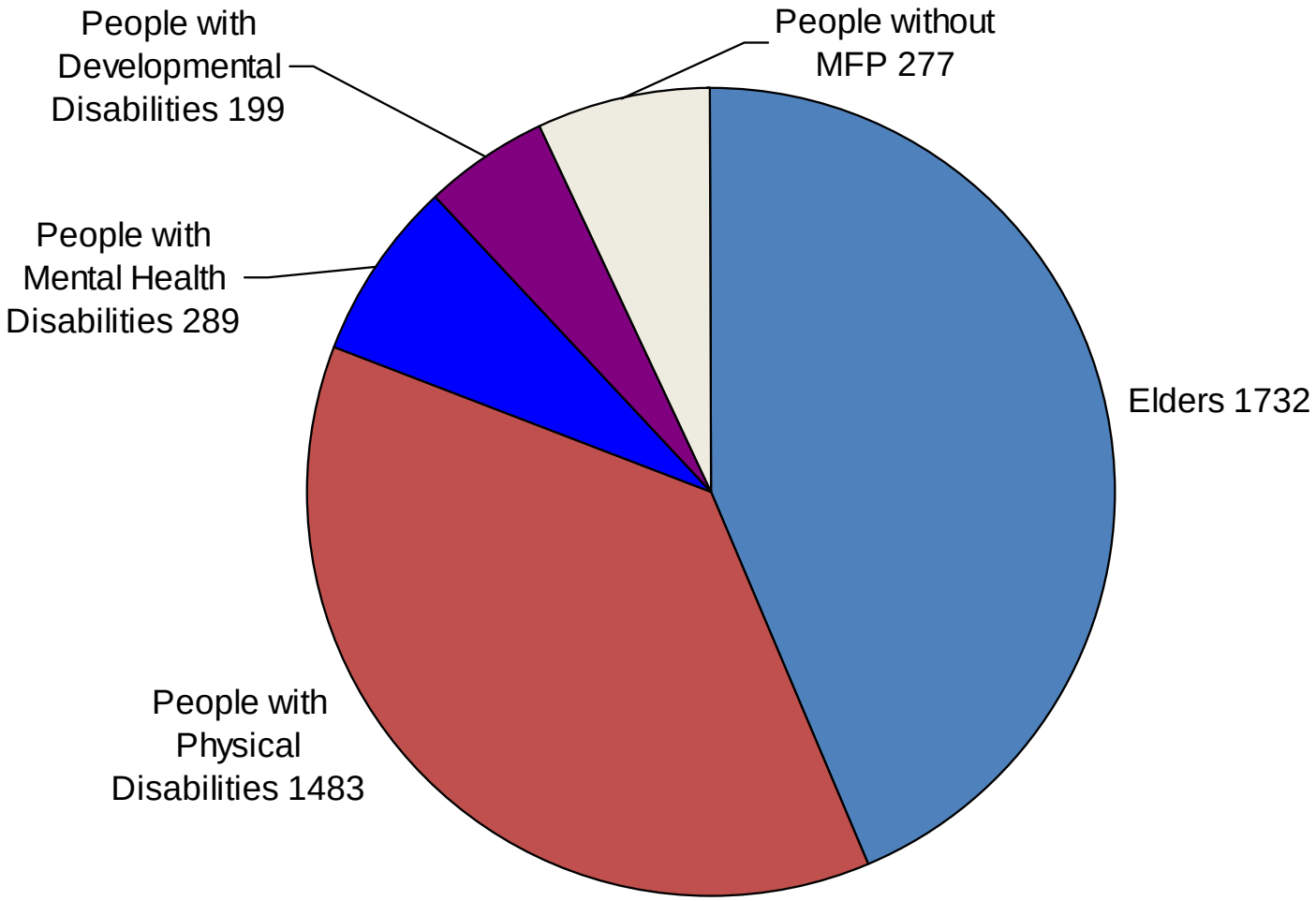
- We are the **first Money Follows the Person project in the country to be featured in a peer-reviewed journal** – *Health Affairs*

The results of this study show that ***Connecticut's Money Follows the Person program has largely succeeded in addressing concerns raised by policy makers, advocates, families, and residents of institutions about safety, quality of life, and life satisfaction following a transition to the community*** *. . . National and state policy makers can gain insights from these findings to identify areas to target that could prevent the use of acute care services and reinstitutionalization after transition, as well as to ensure high quality of life and global life satisfaction for older adults and people with disabilities living in the community.*

Information

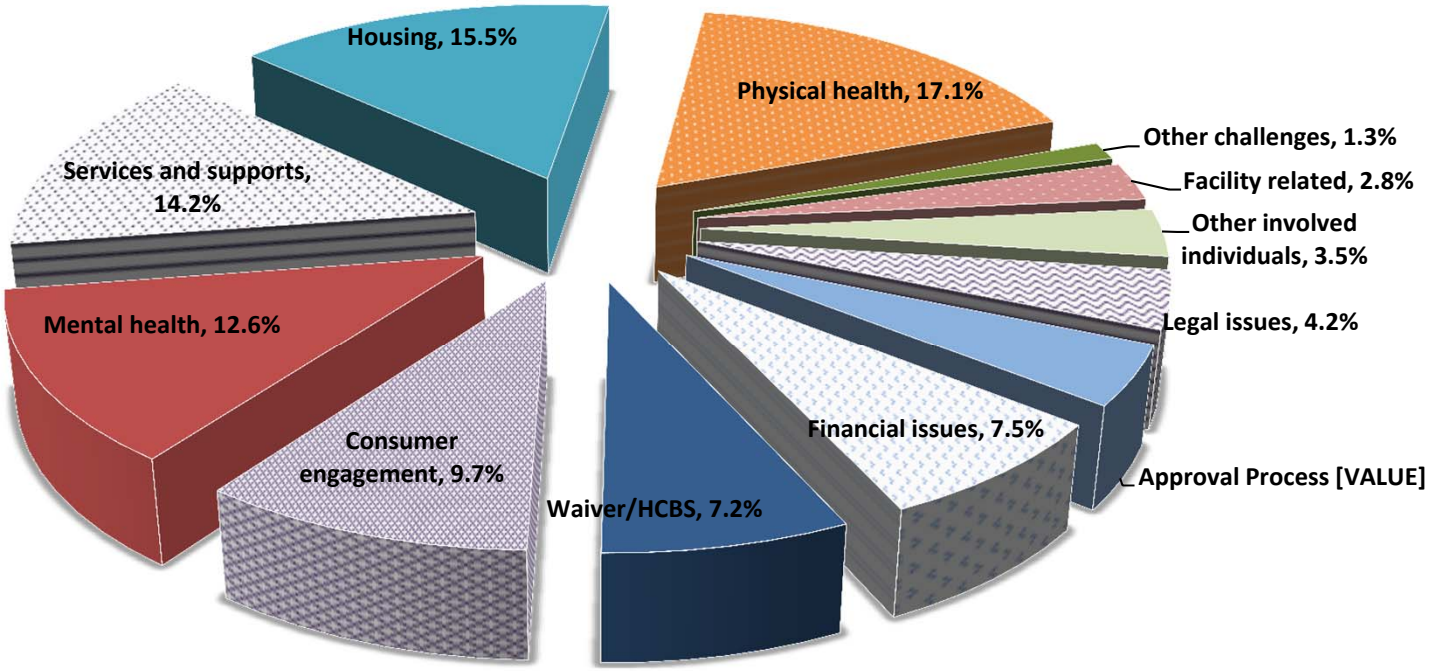
- Through 9/19/2016, we have transitioned 3,980 individuals from nursing facilities to the community under MFP.
- This figure has continued to increase year over year.
- In SFY'14, we served 61% of individuals who receive Medicaid LTSS in community settings, and spent 29% of Medicaid LTSS dollars on HCBS.
- **We have proven results concerning integration and life satisfaction, for individuals who have transitioned.**

Detail on Transitions through 9/19/16



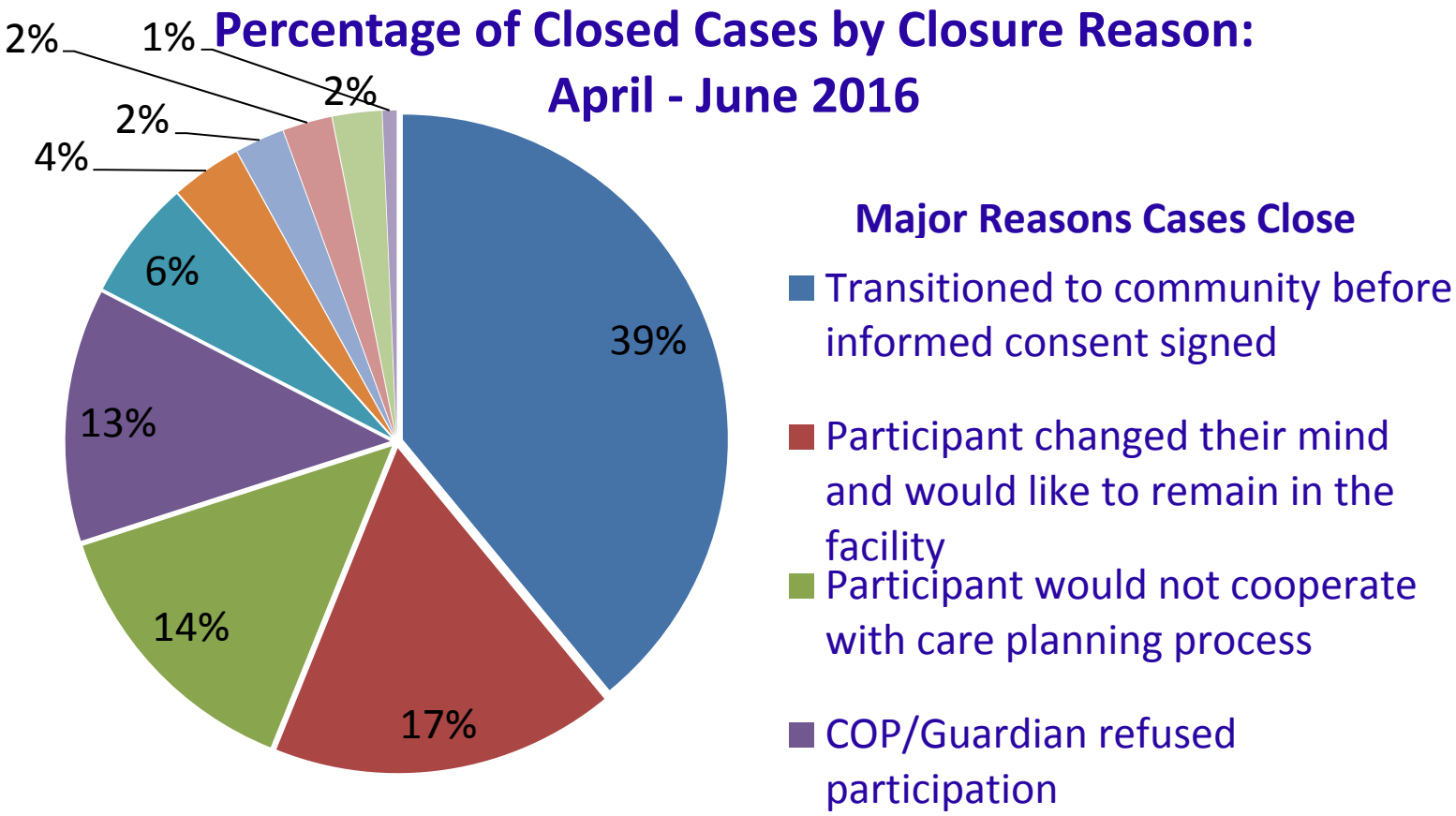
Improved Transitions to Community

We have studied the challenges experienced by people in the transition process and created new initiatives to address the challenge.



Improved Transition Process

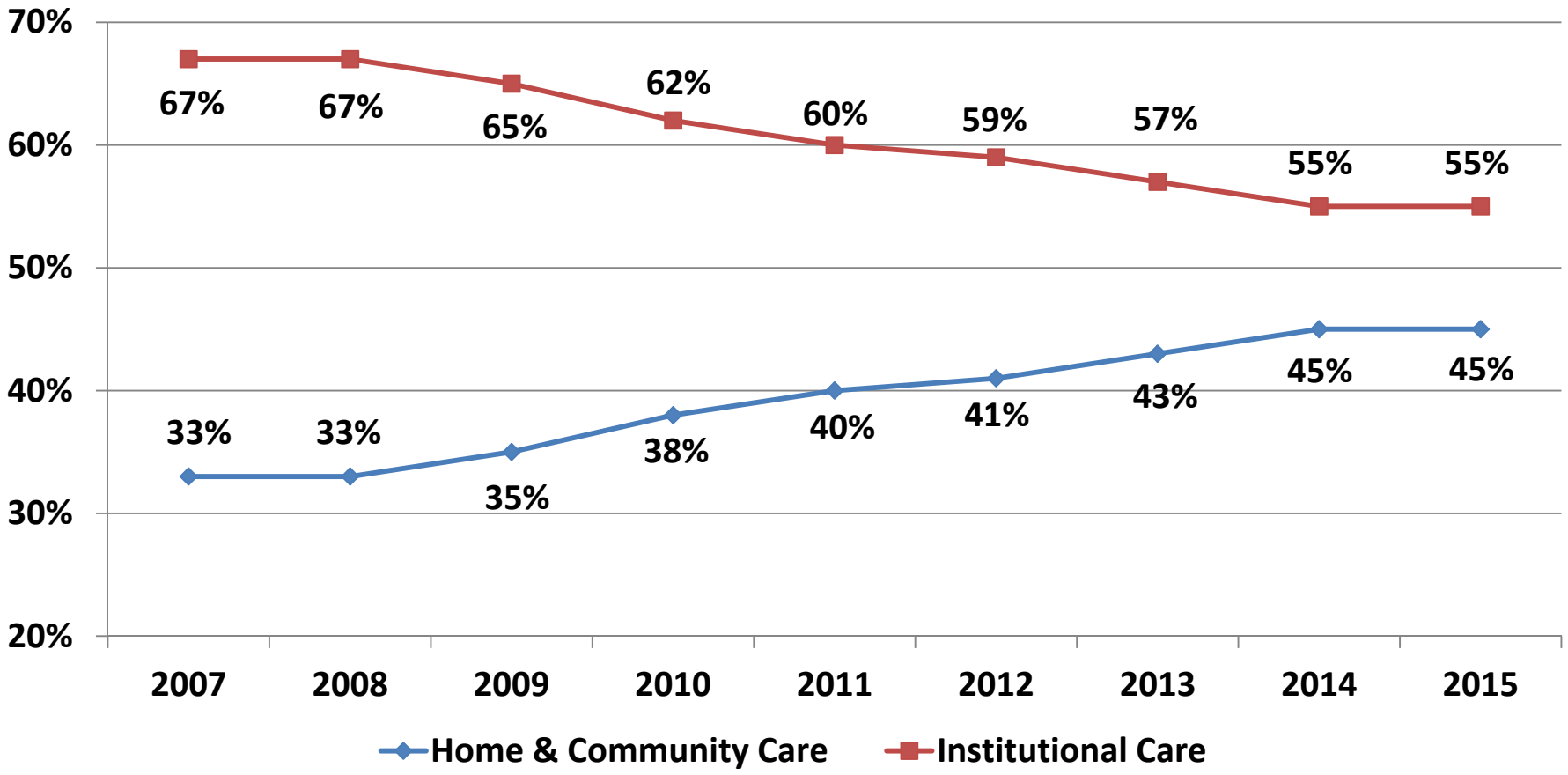
We have studied the reasons that people are unable to successfully transition and created new procedures and training.



CT Medicaid LTSS Expenditures

Increase dollars to home & community-based services

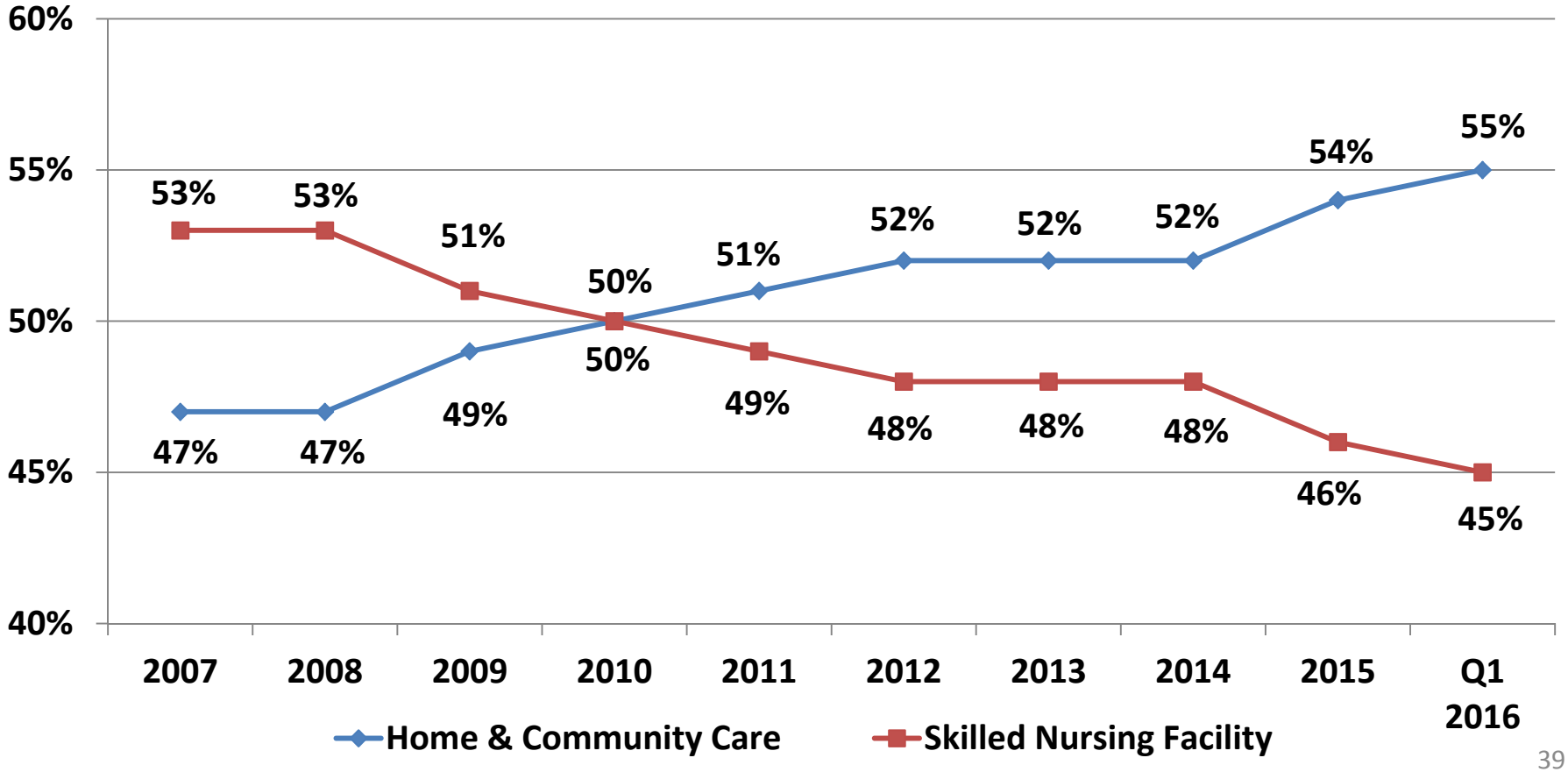
Source: Office of Policy and Management



Percentage of Hospital Discharges to Home & Community Care vs. Skilled Nursing Facility

Increase hospital discharges to the community rather than to institutions

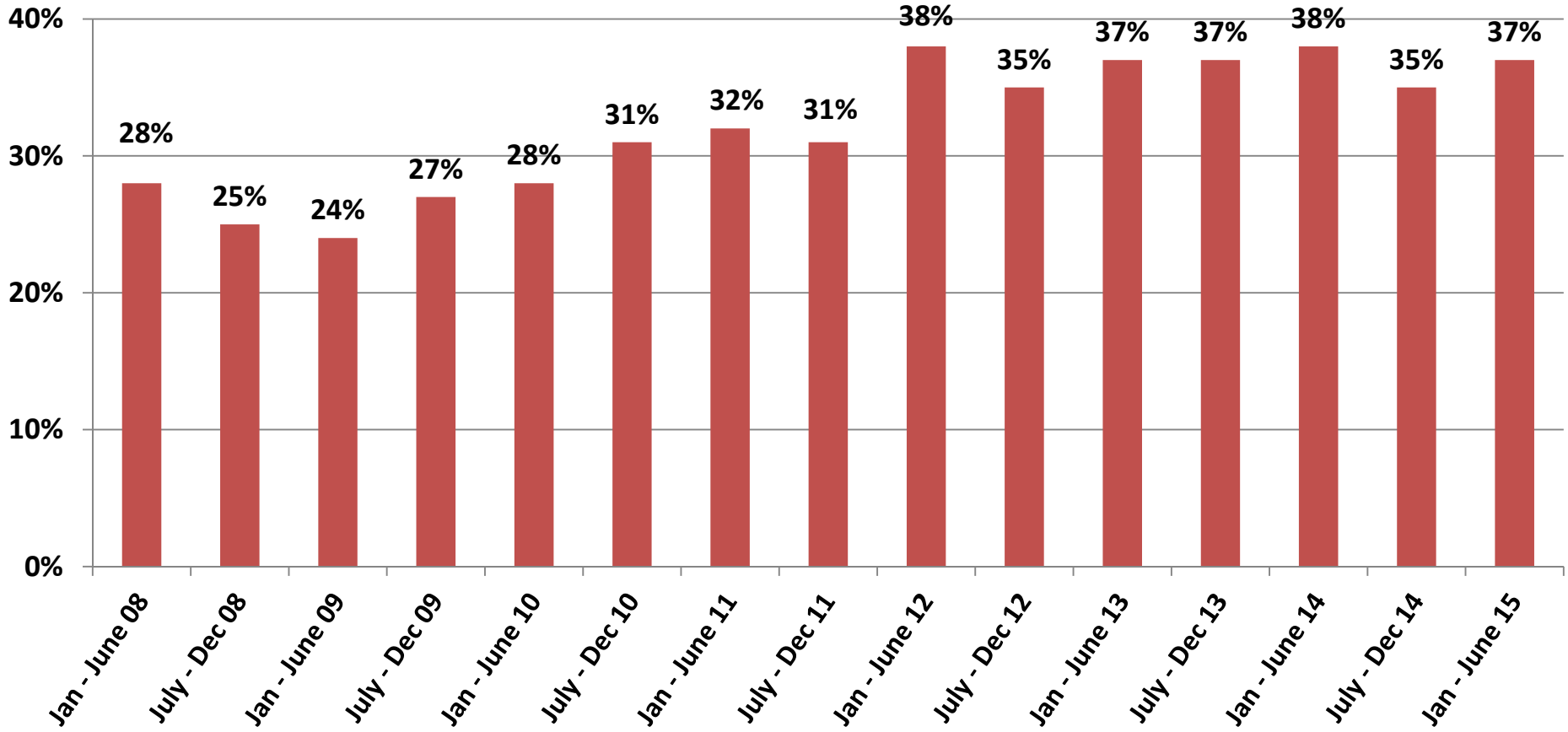
Data Source: Connecticut Office of Health Care Access



Percent of SNF Admissions Returning to the Community within 6 Months

Increase probability of returning to the community during the 6 months following nursing home admission

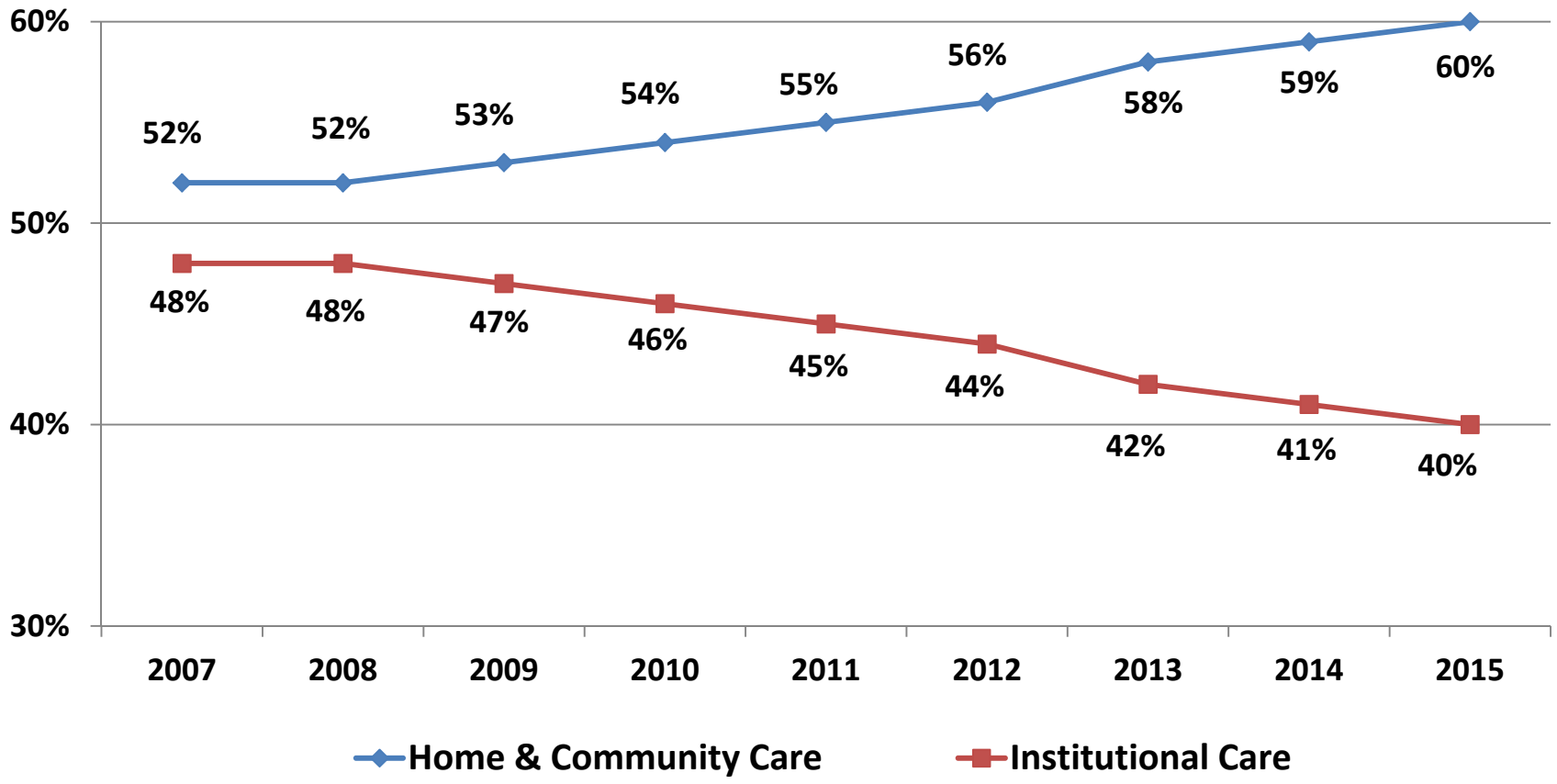
Source: Center on Aging, University of CT



Percent Receiving LTSS in the Community vs. Institutions

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

Data Source: Office of Policy & Management, Trends in Long-Term Care Annual Report



Information

- We have increased the percentage of people who:
  - **are happy with the way they live their lives** - from 62% while institutionalized to 79% after their move to the community
  - **report that they are doing fun things in their communities** - from 42% while institutionalized to 60% after their move to the community
  - **report that they are being treated the way in which they wish to be** - from 82% while institutionalized to 93% after their move to the community

Overview of Trends

In summary . . .

- **We have enabled thousands of people to avoid institutionalization with community-based supports, and have transitioned a significant number of people from nursing facilities to independent living in the community.**
- **We use data to examine and address each and every barrier that inhibits choice and independence.**
- **We are partnering with diverse entities including nursing facilities to create the LTSS system of the future.**

Questions?