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ResearchReport

Connecticut's Long-Term Care Rebalancing Initiatives

By: Nicole Dube, Principal Analyst
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Issue

Provide a brief overview of Connecticut's major long-term care rebalancing initiatives, specifically the Connecticut Homecare Program for Elders, Money Follows the Person, and Community First Choice. Also provide information on Connecticut's long-term care rebalancing ratio (i.e., how much the state spends on Medicaid long-term care in institutions vs. the community) and how Connecticut compares to other states.

Summary

Like other states, Connecticut has faced an increasing elderly population, high nursing home Medicaid costs, and an increasing desire among the elderly and individuals with disabilities to remain in their own homes while receiving care. As a result, the state has implemented various efforts to reduce the number of people in institutions and increase the number of people served by home- and community-based services (HCBS), as part of an overall effort to "rebalance" the long-term care system. Examples of these initiatives include the:

1. Connecticut Homecare Program for Elders (CHCPE), which provides HCBS to eligible seniors who are at risk of institutionalization or meet a nursing home level of care;

2. Money Follows the Person (MFP), a federal demonstration program that helps eligible Medicaid recipients transition out of institutional care into community-based settings; and

3. Community Choice First, which enables Medicaid recipients who require an institutional level of care to self-direct community-based services using individual budgets, with the support of a fiscal intermediary.

States' rebalancing success is often measured by the percentage of total Medicaid long-term care spending on HCBS. Connecticut's Long-Term Care Planning Committee set a statewide goal of serving 75% of Medicaid long-term care recipients in home- and community-based settings by 2025, with only 25% receiving institutional care. According to the committee's most recent report to the legislature, in 2015, 59% of Medicaid recipients received long-term care in the community and 41% received such care in institutions. This represents a three percent increase in Medicaid recipients receiving HCBS in 2012.

The American Association of Retired Persons (AARP) is one organization that ranks state's Medicaid long-term care performance. Its national 2017 Long-Term Services and Supports Scorecard ranks states' performance in five main categories (1) affordability and access, (2) choice of setting and provider, (3) quality of life and quality of care, (4) support for family caregivers, and (5) effective transitions between nursing homes, hospitals, and homes. Connecticut ranked 10th overall and 2nd for affordability and access, but ranked 38th for effective transitions.

Connecticut's Major Long-Term Care Rebalancing Initiatives

Connecticut Home Care Program for Elders (CHCPE)

CHCPE provides home- and community-based services for eligible seniors age 65 or older who are at risk of institutionalization or meet nursing home level of care. Services include homemaker, companion, personal emergency response system, meals on wheels, adult day care, chore, mental health counseling, personal care attendant, assistive technology, adult family living, care management, and minor home modifications.

CHCPE is funded by both Medicaid (Categories 3 and 5 of CHCPE) and the state (Categories 1, 2, and 4). Individuals who are eligible for the Medicaid-funded portion of the program also qualify for regular Medicaid state plan services. Applicants must meet the functional and financial eligibility criteria for one of the five categories of eligibility (see Table 1 below). As of November 2016, the program served a total of 16,370 individuals and there were 390 individuals on a wait list for services.

Cost Limits on Care Plans. As shown in Table 1 below, an individual's eligibility category determines the maximum budget (i.e., cost cap) for his or her care plan. According to PRI's study, prior to 2016, the state's cost for an individual's care plan could not exceed the average weighted

state cost of nursing home care. But, after personal care assistants were unionized, the cost caps increased to 115% of the average weighted cost of nursing home care. (This is because unionization required additional expenses for overtime pay.) Therefore, the new cost limits for Category 3 CHCPE participants have the highest caps of $6,690 per month or $80,280 annually.

Table 1. Connecticut Homecare Program Eligibility Categories

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

Source: Legislative Program Review and Investigations (PRI) study, Factors Influencing Receipt of Long-Term Care Services and Supports in Home and Community Settings: page 18

Income and Asset Limits. For the Medicaid-funded portion of CHCPE, the monthly income limit is currently $2,205 for the individual who receives the services. The asset limit is $1,600 for an individual receiving services, or $3,200 per married couple if both receive services. If only one spouse in a married couple receives services, the spouse not receiving services is allowed to keep a higher amount to avoid impoverishment. In such a case, the asset limit is $25,780 per couple, or higher in certain circumstances.

The state-funded portion currently has no income limit; asset limits are $36,270 for an individual and $48,360 for a married couple, regardless of whether one or both are receiving services.

Cost Sharing. By law, state-funded participants must contribute to the cost of their care, depending on the extent to which their incomes exceed the federal poverty level (FPL). Those with income up to 200% of the FPL must contribute 9%; those with income over 200% of the FPL must contribute 9% of the cost of care plus an applied income amount DSS determines. Certain people living in affordable housing under the state's assisted living demonstration program are exempt. The cost sharing amount was implemented legislatively in 2010 and has changed several times as follows:

1. January 2010: 15 percent (inception of copay)
2. July 1, 2010: 6 percent
3. July 1, 2011: 7 percent
4. July 1, 2015: 9 percent

Participant and Cost Information. According to DSS's most recent annual program report (November 2016), there were 16,315 participants at the end of FY 15, approximately 73% of which were funded by Medicaid. FY 15 program expenditures totaled $379,162,412 before federal reimbursement. The state received $166,379,020 in federal Medicaid reimbursements, resulting in a net cost to the state of $212,783,392. Services provided in the state-funded categories totaled $46,404,373 in FY 15, compared to $325,573,058 in the Medicaid-funded categories.

Money Follows the Person (MFP)

The MFP federal demonstration program serves the elderly and individuals with mental illness and developmental disabilities by offering (1) enhanced Medicaid reimbursement for services for the first 12 months the participant lives in the community (i.e., 75%, instead of 50% reimbursement) and (2) flexibility to provide supplemental support services, such as housing coordinators, that Medicaid does not typically cover. States must continue to provide community-based services after the 12-month period for as long as the person remains Medicaid eligible and in need of services. States are also expected to reinvest the savings they realize through the program. Connecticut is one of 43 states, plus the District of Columbia, participating in the program.

The program began in 2007 and was extended through 2016 by the Affordable Care Act. States may use any remaining 2016 grant funds until 2020; no additional funding is expected after the final 2016-2020 awards are made. States can request to continue transitioning MFP participants until December 31, 2018 and receive the enhanced match through December 31, 2019. All service claims must be finalized by September 30, 2020.

DSS implemented MFP in December 2008. To qualify, a person must (1) have been institutionalized for at least 90 days and (2) meet Medicaid eligibility criteria. In addition, it cannot cost more to care for the person in the community than in an institution. After someone qualifies for MFP, DSS assesses the person's service needs, develops a care plan, and helps the person find housing and services.

For FY 17, MFP received 1,896 applications and supported 742 individuals in transitioning from institutional facilities to the community. Of these, 304 of these were elders (over age 65), 321 were under age 65 with physical disabilities, 38 had behavioral health conditions and 44 had intellectual disabilities. An additional 35 participants who did not meet MFP criteria were also transitioned. Total state expenditures for FY 17 were $10,772,833 and federal reimbursements received for FY 17 totaled $34,156,629. As of June 30, 2017, DSS transitioned a total of 4,447 institutionalized people into the community since the program's inception, with an additional 716 participants expected to transition in FY 18.

Community First Choice (CFC)

In 2015, DSS implemented CFC, a new Medicaid state plan service under 1915(k) of the Social Security Act. This optional state plan service was established under the Affordable Care Act and enables Medicaid beneficiaries who require an institutional level of care to self-direct community-based services using individual budgets, with the support of a fiscal intermediary. They can hire from pools of qualified staff or they can hire certain family members and friends. CMS provides Connecticut an additional 6% in federal Medicaid reimbursements in addition to the regular 50% reimbursement rate.

Program services include PCAs, home delivered meals, home safety modifications, emergency response systems, and assistive technology. Staff can be used to take participants to community activities and medical appointments, and help with errands.

Long-Term Care Rebalancing

Where Does Connecticut Stand?

The Long-Term Care Planning Committee's 2016 Statewide Long-Term Services and Supports plan calls for the state's Medicaid program to serve 75% of its long-term care clients in home and community based settings by 2025, with only 25% choosing institutional care. According to the committee's most recent report to the legislature, for FY 15, 45,876 Medicaid recipients received long-term care of which 59% received these services in the community and 41% received them in institutions. The percent of Medicaid long-term care clients receiving services in the community has increased 3% since 2012, when the rebalance ratio was 56% for Medicaid home- and community-based services and 44% for institutional care (see p. 5 of the report).

Where Does Connecticut Rank?

AARP's national 2017 Long-Term Services and Supports Scorecard ranks states' performance in five main categories (1) affordability and access; (2) choice of setting and provider; (3) quality of life and quality of care; (4) support for family caregivers; and (5) effective transitions between nursing homes, hospitals, and homes. Connecticut ranked 10th overall with Washington, Minnesota, and Vermont performing the highest and Alabama, Kentucky, and Indiana performing the lowest.

Table 2 provides more detail about Connecticut's ranking. As the table shows, Connecticut ranked 2nd among states in terms of affordability and access, but 38th for effective transitions.

Table 2. Connecticut: 2017 AARP Long-Term Services and Supports Scorecard Results

Category	Rank	Number of Indicators with Trend	Number of Indicators Showing		
			Substantial Improvement	Little or No Change	Substantial Decline
OVERALL	10	23	7	13	2
Affordability and Access	2	5	0	5	0
Choice of Setting and Provider	16	5	2	2	0
Quality of Life and Quality of Care	18	3	1	1	1
Support for Family Caregivers	12	4	2	2	0
Effective Transitions	38	6	2	3	1

Source:http://www.longtermscorecard.org/~/media/Microsite/State%20Fact%20Sheets/Connecticut%20Fact%20Sheet.pdf

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