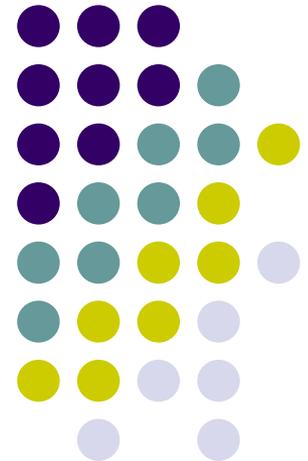
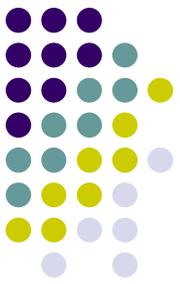


Money Follows the Person Rebalancing Demonstration Legislative Status Update October 2009



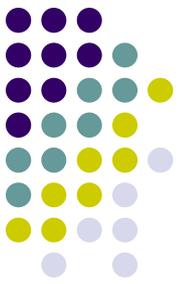


Introduction

Money Follows the Person is a Connecticut initiative designed to promote personal independence and achieve fiscal efficiencies. It is funded by the U.S. Centers for Medicare and Medicaid Services and the State of Connecticut as part of a national effort to “rebalance” long-term care systems, according to the individual needs of persons with disabilities of all ages.

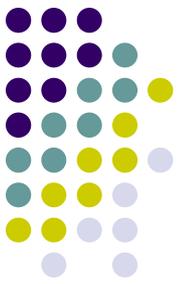
The Connecticut Department of Social Services extends thanks to Governor M. Jodi Rell for her leadership in this area, and to the Connecticut General Assembly for its support of this initiative.

Overview of Status Update



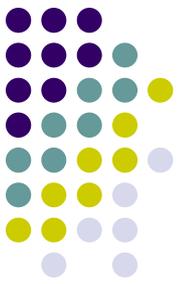
- Goals
- Progress to date
- Challenges
- Next Steps

Goals of the Money Follows the Person (MFP) Demonstration



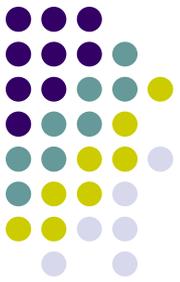
- Reduce reliance on institutional care
 - Design and implement a program that helps people move from institutions back to the community and supports them with community services.
- Increase effectiveness and efficiency of the long-term care system
 - Design and implement changes supporting the State's capacity to develop high-quality care in the community.

MFP Goals in Connecticut



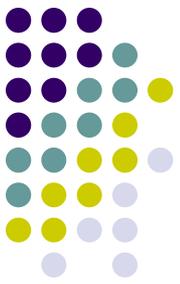
- Transition 700 people by December 2012
- Increase hospital discharges to home and community services rather than institutions;
- Increase percentage of persons receiving long-term care services in the community;
- Increase probability of returning to community within first 6 months of admission to institution through existing Medicaid programs;
- Required Initiatives:
 - Quality Improvement
 - Information Technology
 - Housing
 - Workforce Development

MFP Partnerships



- Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
- Department of Developmental Services
- Department of Mental Health and Addiction Services
- Department of Economic and Community Development
- Office of Policy and Management
- U.S. Department of Housing and Urban Development
- Department of Public Health
- Center for Aging, University of Connecticut
- 28 transition coordinators working at a local level within Area Agencies on Aging and Independent Living Centers
- A 25-member steering committee comprised of stakeholders including Commission on Aging, National Alliance on Mental Illness, National Association of Social Workers (CT Chapter), Ombudsman, DSS Bureau of Rehabilitation Services, Brain Injury Association, Board of Education Services for the Blind, University of Hartford, DSS Aging Services Division, CT Legal Services, Leeway Inc., M.S. Society, AARP, ARC, people with disabilities and family members
- 5 housing coordinators located at FSW, Inc., HOME, Inc., and Housing Education Resource Center
- Emergency Back-Up Triage located at Connecticut Community Care Inc

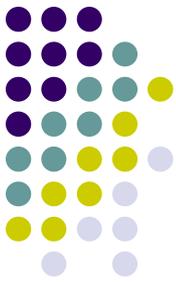
MFP Rebalancing Target by December 2012



- Transition 700 people to the community with MFP Services
 - Eligibility:
 - Institutionalized for 6 months; and,
 - Eligible for Medicaid in the community; and,
 - Community service cost equal to or less than institutional cost.

Note: Connecticut receives enhanced Federal Financial Participation (FFP) in Medicaid expenditures on behalf of people who meet this criteria. Currently the enhanced FFP is approximately 80% of up-front state Medicaid expenditures for the first year of community living.

700 Projected Transitions by Target Waiver as Approved in Operating Protocol



Number of People Transitioning by Target Population by Calendar Year								
Target Group	Physical Disability				Mental Health	Mental Retardation		Total
Target Waiver	Elderly	PCA	ABI	Chronic Care		Ind	Comp	
2009	95	51	11		46	11	11	227
2010	78	41	10	2	41	10	10	204
2011	94	49	13	14	54	13	13	269
Total	267	141	34	33	141	34	34	700
Percentage	38%	20%	5%	49%	20%	5%	5%	100%

Key

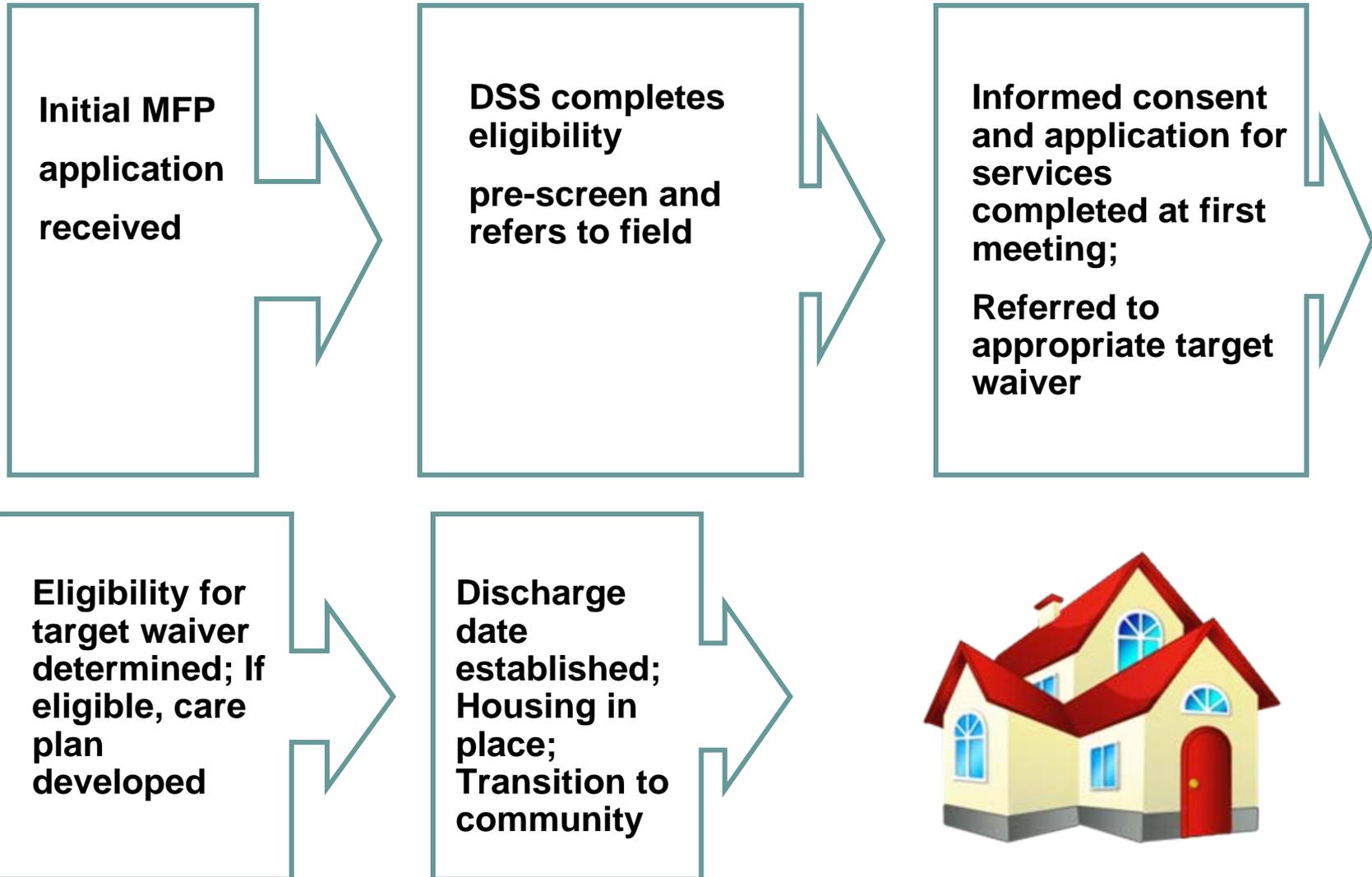
PCA: Personal Care Assistance

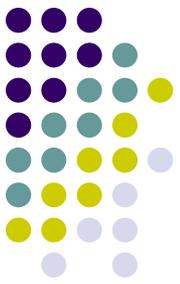
ABI: Acquired Brain Injury

Ind: Individual Family and Support

Comp: Comprehensive

Transition Process

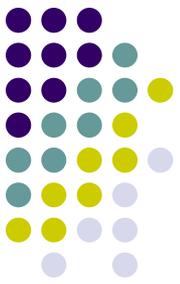




Transition Status – September 2009

- **946 Applications received, representing residents in 157 different skilled nursing facilities;**
- **801 Applications screened by Department of Social Services and referred to contracted community partners;**
- **601 Applicants received at least 1 visit from field staff, signed an informed consent to participate in MFP and initiated the transition planning process;**
- **248 Applicants completed a clinical assessment, have an approved care plan and are in final stages of transition – hiring staff, looking for housing, waiting for completion of home modifications;**
- **211 Care plans in development and not yet approved;**

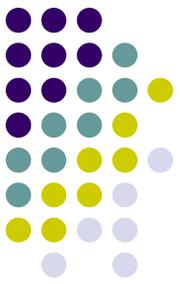
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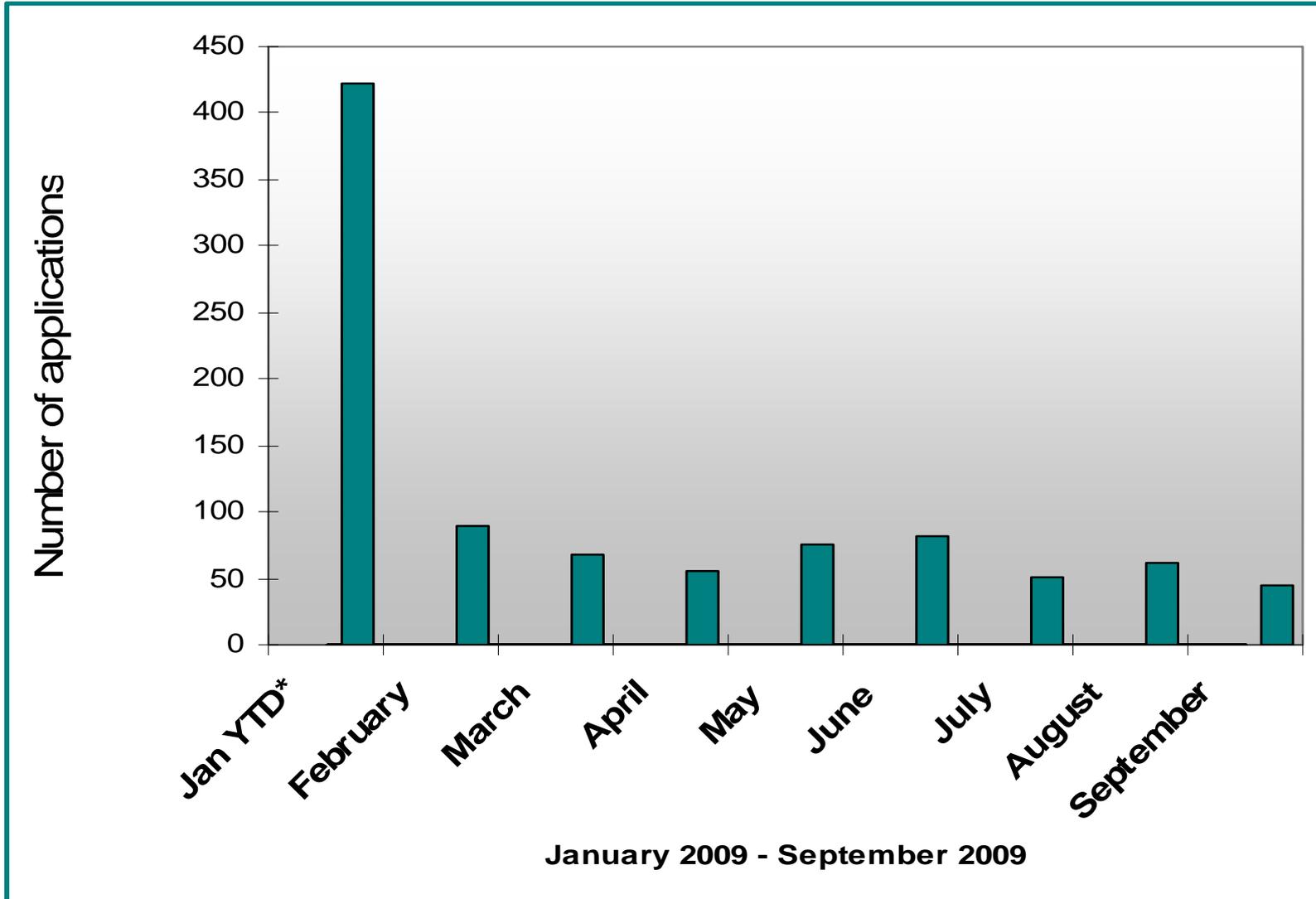
Transition Status – September 2009

Continued

- **95 Persons transitioned from 54 different nursing homes. The highest number of persons transitioned from any single nursing home was 4.**
- **164 cases closed (See detail on slide 19)**

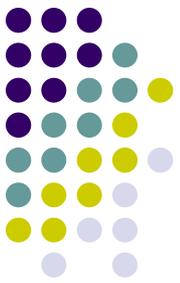


Applications Received by Month



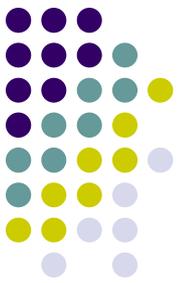
*Note: January YTD includes applications submitted for the months of December and January.

Common Factors Impacting Time in Transition



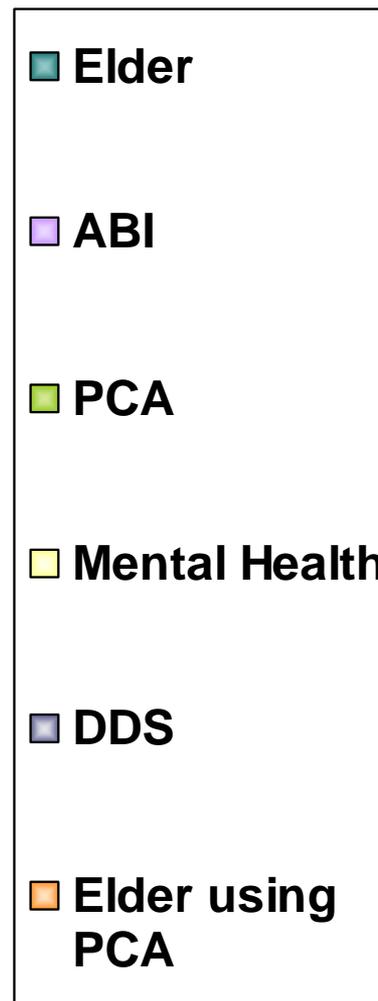
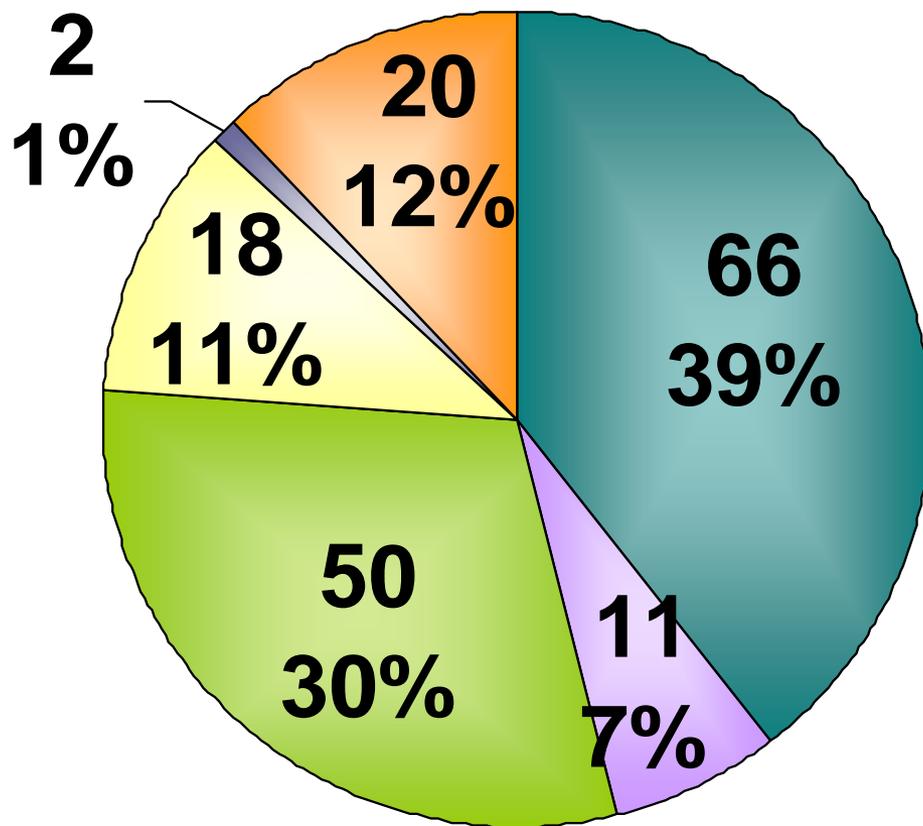
Transition timeframe factors	Factors involved in transition planning and disposition
33% of applicants waiting for evaluation from waiver agency	Retirement Incentive Program: <ul style="list-style-type: none">➤ Initial loss of regional social work staff and process related to hiring of replacement staff. Other expense reductions: <ul style="list-style-type: none">➤ Cultural shift of how to work with fewer state vehicles; impact on timely completion of assessments at nursing homes.
20% of applicants experiencing problems with housing	<ul style="list-style-type: none">➤ Lack or insufficient housing➤ Delays related to working with housing authority➤ Housing modification process – working with contractors➤ MFP participants' preference

Common Factors Impacting Time in Transition

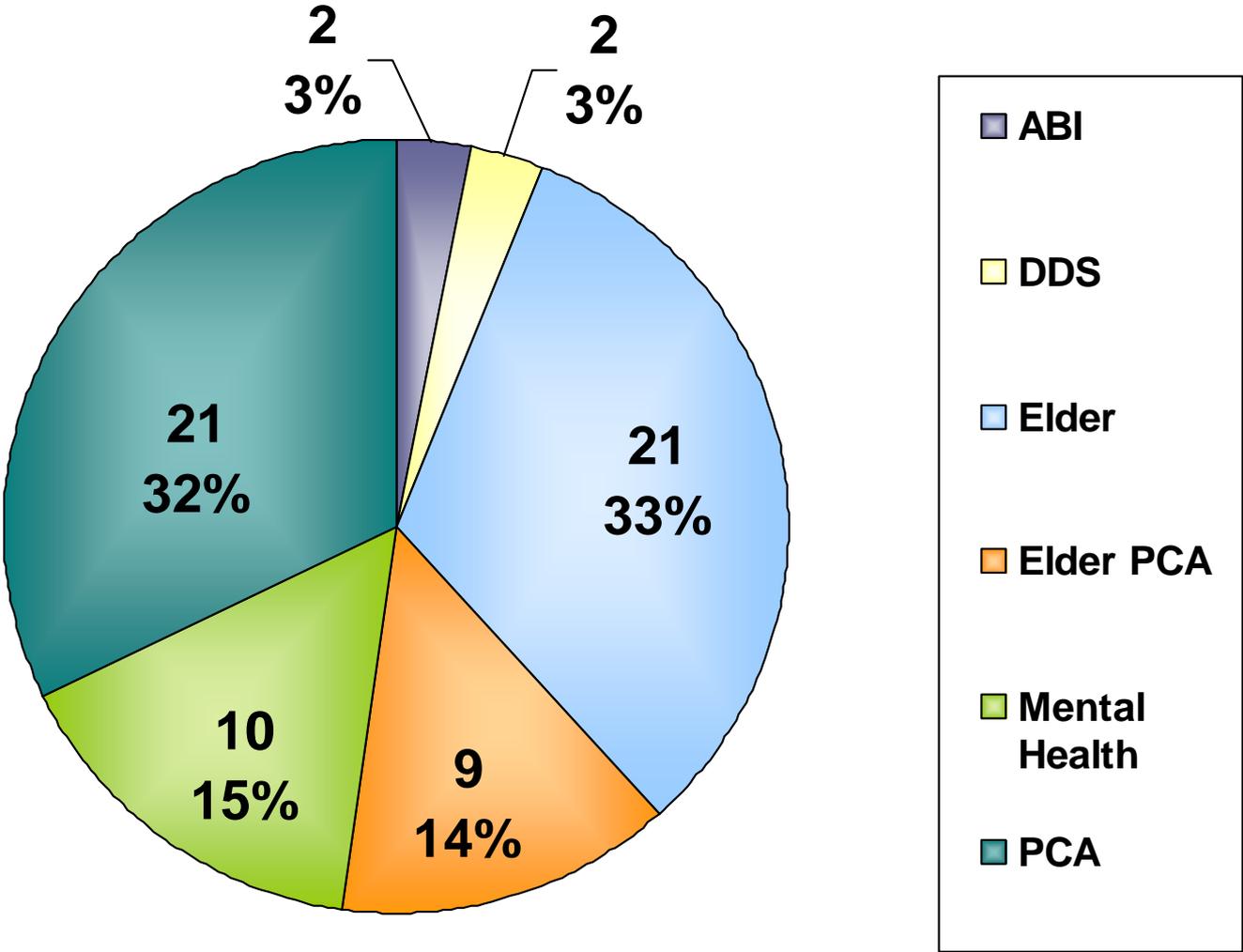


Transition timeframe factors	Factors involved in transition planning and disposition
16% of applicants experiencing delays since they were not found eligible for wavier services	<ul style="list-style-type: none">➤ Applicant does not require assistance with 2 activities of daily living➤ Current waivers do not meet the applicant's needs➤ Eligibility for nursing home admission is less restrictive than eligibility for waiver
9% of applicants experiencing family or friend issues related to their transition	<ul style="list-style-type: none">➤ Discussions about risks in the community➤ Discussions about responsibility of hiring staff➤ Discussions about responsibility of informal caregivers, including their role in the participant's back-up plan

Distribution of 167 Care Plans Approved for Target Waivers



65 MFP Enhanced Match Transitions by Target Waiver



Total Monthly Cost of Institution vs. Community Care Plan

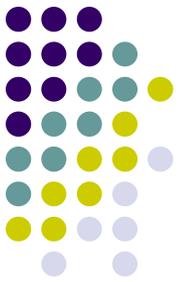


- 65 MFP participants eligible for enhanced FFP
 - Monthly community care plans total – \$238,950
 - Monthly service plans total \$220,200
 - Monthly rent costs for 25 of the 65 participants – \$18,749
 - Monthly institutional cost for the same people – \$432,780
- 30 MFP participants not eligible for enhanced FFP
 - Monthly community care plans total – \$71,696 (17 participants did not require a care plan upon transition)
 - Monthly service plans total -\$67,946
 - Monthly rent costs for 5 of the participants - \$3,750
 - Monthly institutional cost for the same people – \$179,874

Note: Actual service utilization of an approved care plan is estimated at 80% of the actual care plan cost. The group of MFP participants not eligible for enhanced FFP includes 3 persons who transitioned to group homes. Their costs are not included in the analysis.

All participants are eligible for services under the Medicaid State Plan.

Program Cost Comparison Per Client



Institutionalized Care (SNF)

VS

Money Follows the Person

- Monthly Program Cost \$6,658
- Federal Match \$4,008
- Net Cost to State \$2,651

- Monthly Program Cost \$3,676
 - MFP Services \$3,388
 - Rental Assistance \$288
- Federal Match \$2,713
- Net Cost to State \$963

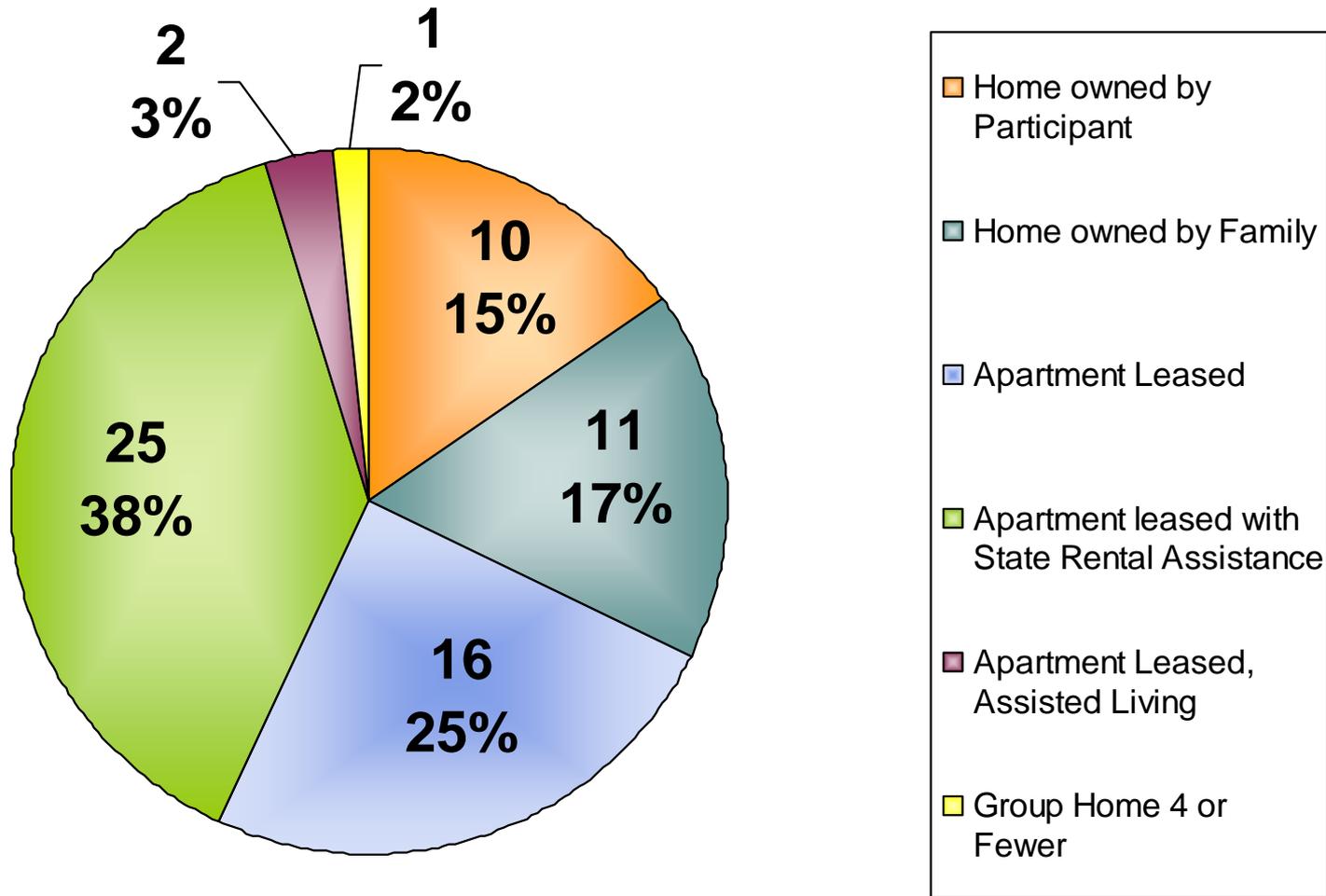
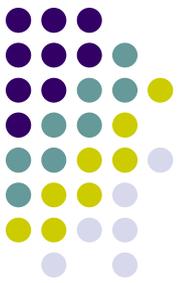
Note: Does not include Administration Costs.

Actual service utilization of an approved care plan is estimated at 80% of the actual care plan cost.

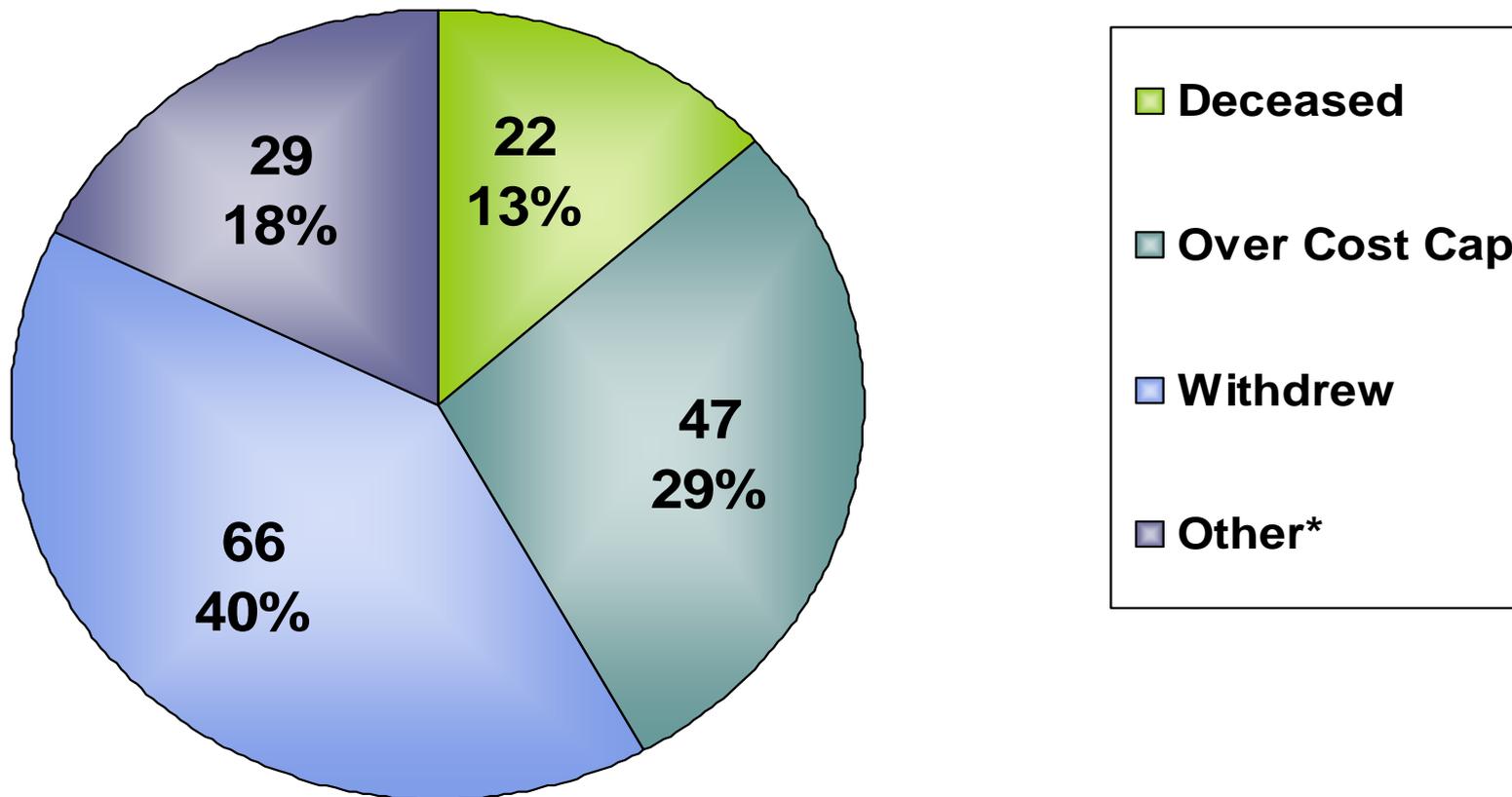
The group of MFP participants not eligible for enhanced FFP includes 3 persons who transitioned to group homes. Their costs are not included in the analysis.

All participants are eligible for services under the Medicaid State Plan.

MFP Enhanced Match Transitions by Housing Type

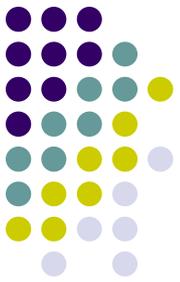


Analysis of 164 Cases Closed Prior to Transition out of 946 Applicants



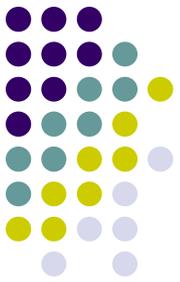
*Reasons include refused assessment, conservator concerns, medically unstable

Quality Management Enhancements



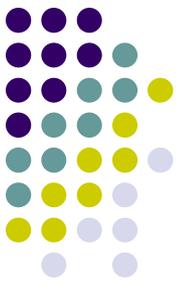
Action Completed	Benefit
Designed, developed and implemented web-based case management system	Supports the sharing of information across departments partnering with MFP; Provides 24/7 Triage System with access to important emergency back-up plans
Designed, developed and implemented web-based critical incident reporting system	Provides a central data base and analysis of critical incidents for all MFP participants. Analysis of incidents will point to systemic weaknesses across all HCBS and opportunities for improvement.
Designed, developed and implemented MFP Emergency Backup system	Provides all MFP participants with 24/7 assistance to help with transportation problems, durable medical problems and personal care support in the community.

Systems Improvements – Inter-departmental Coordination for the Benefit of MFP Participants



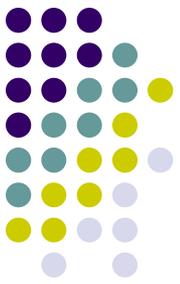
Action Completed	Benefit
Centralized eligibility determination within MFP unit	Provides priority status for granting community Medicaid services to MFP population; Assures compliance with CMS rules for tracking MFP participants; Assures coordination of granting Medicaid services with the transition discharge date.
Centralized program administration for rental assistance and security deposit guarantee within MFP unit	Simplifies, expedites and coordinates approvals for programs with transition discharge date.
Created inter-departmental agreement to share information regarding income, citizenship, documents, etc.	Shortens transition time since MFP applicants are not required to produce documents a second time.

Status on Information Technology: Improved Data Tracking Capability

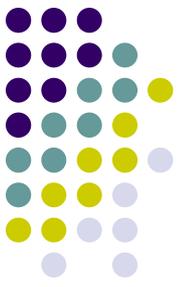


- Eligibility Management System and Interchange modifications in place to track all MFP participants;
 - This allows us to produce reports and analyze all service utilization expenditures for MFP participants;
 - This also allows us to monitor reinstitutionalization, including hospitalization.

Status on Workforce Development and Housing



- Workforce Initiative
 - Develop statewide map of existing direct workforce activities and report, informing strategy in final stages of completion;
- Housing Initiatives
 - Partnering with Contractors to increase inventory of affordable accessible housing;
 - Partnering with Section 202 funded housing to obtain more HUD funding for the purpose of converting units to assisted living;
 - Partnering with a minimum of 3 Housing Authorities in competitive application for additional Section 8 vouchers;
 - Partnering with Neighborhood Stabilization Communities funded by HUD.



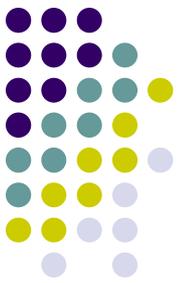
MFP Rebalancing Target by December 2011

Increase probability of returning to community within first 6 months of admission to institution.

Calendar Year	Ratio (percentage) of Medicaid beneficiaries who move back to the community from a nursing facility within six months of institutionalization to total number admitted to nursing facilities. (Percentages will be calculated as a quarterly average)		
	Target	Actual	% Achieved of Target
2008	39	34	87
2009	40	32	80
2010	41		
2011	42		

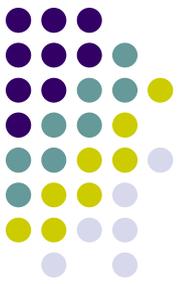
Status Update:

Increase probability of returning to community within first 6 months of admission to institution.



- Developed ‘fast track’ triage system
 - Establishes coordinated process to transition within 30 days or less if key indicators are documented;
- Piloting MDS 3.0 Section Q for CMS
 - Provides opportunity to establish a formal link between nursing home resident assessments and the MFP transition process;
 - Developed a resident ‘challenge to transition’ identification tool for use by both nursing homes and MFP transition staff to assure communication and collaboration.

MFP Rebalancing Target by December 2011

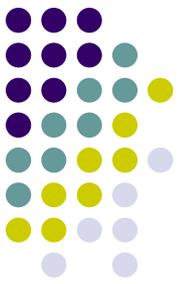


Decrease hospital discharges to nursing facilities among those requiring care after discharge.

	Percentage of persons discharged to the community		
	Target	Actual	% Achieved of Target
2008	49	47	96%
2009	50	47	94%
2010	52		
2011	54		

Status Update:

Decrease hospital discharges to nursing facilities among those requiring care after discharge.



- Developed interview tool for hospital discharge planners;
- Conducted 22 one on one interviews with hospitals statewide;
- Developed list of interventions based on input from discharge planners;
- Web based pre-admission screening tool delayed in 2009.

MFP Rebalancing Target by December 2011



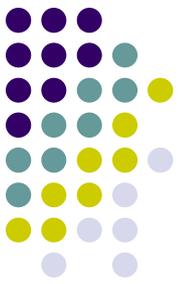
Increase percentage of persons receiving long-term care services in the community relative to the number of persons in institutions. This target includes all participants in Connecticut's Medicaid long-term care system.

- Home and Community Based State Plan Option
- Waiver for persons with Mental Illness
- State plan supports and services

	Target	Actual	% Achieved of Target
2008	53%	52%	98%
2009	54%	53%	98%
2010	55%		
2011	57%		

Status Update:

Increase percentage of persons receiving long-term care services in the community relative to the number of persons in institutions.



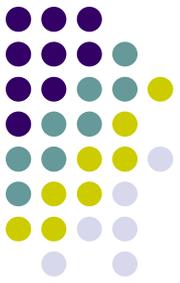
- Assistive Technology added as a service under the PCA waiver;
- UConn Center on Aging completed first phase of research;
 - Collect and analyze data related to:
 - Quality of Life
 - Assistive Technology
 - Gaps in long term care system
 - ❖ **Report Completed: Unmet Needs in the Connecticut Home Care Program for Elders**

Challenges



- Budget concerns, including delay in approval of housing modification funds, unfilled MFP staff positions
 - The original plan for implementation of MFP activities including staff roles and responsibilities had to be redefined.
- Coordination
 - Implementation of MFP requires daily coordination between DDS, DMHAS and DSS.
- Housing
 - Approximately 70% of the people we transition need affordable housing. Many also need accessibility modifications. It takes time to find appropriate housing.
- Self-direction and person-centered planning
 - MFP offers participants the highest degree of choice and autonomy. Many care planners have worked in a more traditional model where staff make service choices for participants. Training is required to assure that staff provide choices for participants and then support the participant's right to choose.

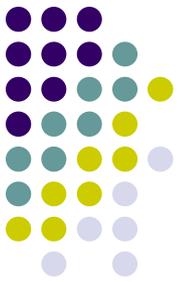
Next Steps



- **MFP II** – Dependent upon availability of funding
 - Expansion from 700 persons transitioned to 5,000;
 - Universal waiver addressing gaps and fragmentation in the existing waiver programs.
- **Housing**
 - Finalize partnerships with communities funded with HUD Neighborhood Stabilization dollars and contractors currently seeking development funds;
 - Assist in development of 3 competitive applications to obtain Section 8 Vouchers.*
- **Workforce**
 - Finalize and distribute statewide map of workforce initiatives related to healthcare;
 - Finalize and distribute report detailing opportunities for addressing workforce shortage.
- **Evaluation**
 - Finalize Phase II of research.
- **Transition**
 - Finalize new case management tool to address high case load;
 - Maintain goal of 16 transitions per month;
 - Finalize MDS 3.0 Pilot.
- **Hospital Discharge**
 - Host focus group to refine activities and initiate plan.

*Note: If we are successful in obtaining more Federal Section 8 vouchers it will reduce the need for State Rental Assistance.

Public Contact information



- **Dawn Lambert, Project Director, Money Follows the Person Rebalancing Demonstration**

Medical Care Administration

Department of Social Services

- Dawn.Lambert@ct.gov
 - www.ct.gov/moneyfollowstheperson
-
- To make a referral call : 1-888-992-8637