CT Money Follows the Person Report
Quarter 2: April 1 - June 30, 2021
UConn Health, Center on Aging

Operating Agency: CT Department of Social Services
Funder: Centers for Medicare and Medicaid Services

MFP Benchmarks
1) Transition 5200 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 the percentage of long term care participants living in the community compared to an institution

Benchmark 1: Total Transitions = 6,816
Demonstration = 6,385 (94%)
Non-demonstration = 431 (6%)

Benchmark 2: CT Medicaid Long-Term Care Expenditures

<table>
<thead>
<tr>
<th>Year</th>
<th>Home &amp; Community Care</th>
<th>Institutional Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>2008</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>2009</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>2010</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2011</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>2012</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>2013</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>2014</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>2015</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>2016</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>2017</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>2018</td>
<td>62%</td>
<td>39%</td>
</tr>
<tr>
<td>2019</td>
<td>63%</td>
<td>38%</td>
</tr>
<tr>
<td>2020</td>
<td>65%</td>
<td>37%</td>
</tr>
</tbody>
</table>

Benchmark 3: Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility

<table>
<thead>
<tr>
<th>Year</th>
<th>Home &amp; Community Care</th>
<th>Skilled Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>2008</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>2009</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>2010</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2011</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>2012</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>2013</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>2014</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>2015</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>2016</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>2017</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>2018</td>
<td>62%</td>
<td>39%</td>
</tr>
<tr>
<td>2019</td>
<td>63%</td>
<td>38%</td>
</tr>
<tr>
<td>2020</td>
<td>65%</td>
<td>37%</td>
</tr>
</tbody>
</table>

Benchmark 4: Percent of SNF admissions returning to the community within 6 months

<table>
<thead>
<tr>
<th>Year</th>
<th>Home &amp; Community Care</th>
<th>Skilled Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>2010</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>2011</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td>2012</td>
<td>36%</td>
<td>64%</td>
</tr>
<tr>
<td>2013</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>2014</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>2015</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>2016</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>2017</td>
<td>36%</td>
<td>64%</td>
</tr>
<tr>
<td>2018</td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>2019</td>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>2020</td>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions

<table>
<thead>
<tr>
<th>Year</th>
<th>Home &amp; Community Care</th>
<th>Skilled Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>2008</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>2009</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td>2010</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>2011</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>2012</td>
<td>43%</td>
<td>58%</td>
</tr>
<tr>
<td>2013</td>
<td>42%</td>
<td>59%</td>
</tr>
<tr>
<td>2014</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>2015</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>2016</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td>2017</td>
<td>36%</td>
<td>63%</td>
</tr>
<tr>
<td>2018</td>
<td>35%</td>
<td>64%</td>
</tr>
<tr>
<td>2019</td>
<td>34%</td>
<td>65%</td>
</tr>
<tr>
<td>2020</td>
<td>33%</td>
<td>66%</td>
</tr>
</tbody>
</table>

Happy or unhappy with the way you live your life

<table>
<thead>
<tr>
<th>Year</th>
<th>Home &amp; Community Care</th>
<th>Skilled Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month</td>
<td>86%</td>
<td>14%</td>
</tr>
<tr>
<td>12 month</td>
<td>81%</td>
<td>19%</td>
</tr>
</tbody>
</table>
Total Number of Referrals Assigned to the Field by Year

Year of Referral


Count

748 707 908 1296 1242 1878 2089 1893 1886 1720 1821 1536

Note: Excludes nursing home closures

Total Number of Transitions by Year

Year of Transition


Count

158 315 434 509 612 596 636 792 792 636 577 535 610

Referrals Assigned to the Field by Quarter

Quarter


Count

501 497 460 435 482 473 523 408 390 515 443 401 491 479 451 450 336 396 359 357 336

Note: Excludes nursing home closures

Number of Transitions by Quarter

Quarter


Count

209 181 207 195 170 169 143 154 141 143 146 148 119 123 134 159 155 153 156 146 118 124

Note: Excludes nursing home closures
Target Population for Transitions by Year of Transition (Demonstration Only)

Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay

Year of Transition

Number of Participants with Home Modifications by Year Approved and Region

Number of Participants with Home Modifications per 6 Months
Participants who are Working and/or Volunteering (data 4/1/21-6/30/21)

Participants under age 65 who are working and those who would like to work

- Working: 36% (1 month), 32% (12 month)
- Want to work: 3% (1 month), 2% (12 month)
- Don't want to work: 62% (1 month), 66% (12 month)

Participants under age 65 who are volunteering and those who would like to volunteer

- Working: 24% (1 month), 12% (12 month)
- Want to volunteer: 3% (1 month), 2% (12 month)
- Don't want to volunteer: 74% (1 month), 86% (12 month)

Participants 65 years and older who are working and those who would like to work

- Working: 94% (1 month), 87% (12 month)
- Want to work: 0% (1 month), 0% (12 month)
- Don't want to work: 8% (1 month), 15% (12 month)

Participants 65 years and older who are volunteering and those who would like to volunteer

- Working: 94% (1 month), 87% (12 month)
- Want to volunteer: 2% (1 month), 13% (12 month)
- Don't want to volunteer: 0% (1 month), 0% (12 month)

Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 6/30/2021

- Apartment Leased By Participant, Not Assisted Living: 71%
- Home Owned By Family Member: 15%
- Home Owned By Participant: 10%
- Group Home No More Than 4 People: 2%
- Apartment Leased By Participant, Assisted Living: 2%
MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed from 4/1/21-6/30/21

1 month interviews done 1 month after transition, n=100
12 month interviews done 12 months after transition, n=107

HCBS CAHPS Composite Measures: Percent with Highest Score (e.g. always, yes)

- Staff are reliable and helpful
  - 1 month: 88%, 12 month: 92%

- Choosing the services that matter to you
  - 1 month: 63%, 12 month: 62%

- Staff listen and communicate well
  - 1 month: 75%, 12 month: 71%

- Planning your time and activities
  - 1 month: 56%, 12 month: 54%

Did any unpaid family members or friends help you with things around the house?

- 1 month: 67% yes, 33% no
- 12 month: 64% yes, 36% no

Depressive Symptoms

- 1 month: 32% yes, 68% no
- 12 month: 34% yes, 66% no

Do you like where you live?

- 1 month: 85% yes, 8% sometimes, 7% no
- 12 month: 73% yes, 11% sometimes, 16% no

Have or Need Assistive Technology (AT)?

- 1 month: 100% have AT, 21% need AT
- 12 month: 97% have AT, 23% need AT
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Jun 2021

- Physical health, 18.7%
- Mental health, 18.1%
- Financial issues, 5.9%
- Consumer engagement, 9.4%
- Services/supports, 22.4%
- Housing, 11.6%
- Waiver/HCBS, 2.3%
- Legal issues, 6.6%
- Facility related, 2.4%
- Other involved individuals, 1.0%
- MFP office /TC, 1.2%
- Other challenges, 0.4%

Frequency of Transition Challenges by Year of Referral

- Physical health
- Mental health
- Financial issues
- Services/supports
- Waiver/HCBS
- Housing
- Consumer engagement
- Legal issues
- Facility related
- Other involved individuals
- MFP office /TC
- Other challenges
Participants with Each Challenge who Transitioned by Referral Year

Types of Challenges for Referrals: 1/1/21 - 6/30/21
Below are the four most common challenge types for the current year

**Physical health**
- Current, new or undisclosed physical health problem
- Inability to manage physical disability or physical illness in community
- Medical testing issues or delays
- Missing or waiting for physical health documents
- Other physical health issues

**Services and supports**
- Lack of alcohol, substance abuse, or addiction services
- Lack of AT or DME
- Lack of mental health services or supports
- Lack of PCA, home health, or other paid support staff
- Lack of transportation
- Lack of any other services or supports
- Lack of unpaid caregiver to provide care/informal support
- Other issues related to services or supports

**Housing**
- Delays related to housing authority, agency or housing coordinator
- Delays related to lease, landlord, apartment manager, etc.
- Needs housing modifications before transition
- Ineligible or waiting for approval from RAP or other housing programs
- Lacks affordable, accessible community housing
- Housing related legal, criminal or credit issues, including evictions or unpaid rent
- Other housing related issues

**Mental health**
- Current or history of substance/alcohol abuse w/ risk of relapse
- Current, new, or undisclosed mental health problem
- Dementia or cognitive issues
- Inability to manage mental health in community
- Other mental health issues
**Frequency of Closure Reason by Year of Closure**

- Participant changed mind
- Wouldn’t cooperate w/ care planning
- Transitioned before informed consent signed
- COP/Guardian refused participation
- Exceeds physical health needs
- Reinstitionalized for 90+ days
- Exceeds mental health needs
- Not aware of referral
- Moved out of state
- Other

Note: Excludes: died, nursing home closure, completed participation, non-demo transition services completed

**Comparison of Closures, Referrals and Transitions per Quarter**

- Total closures excluding: died, nursing home closure, completed participation, non-demo transition services completed
- New referrals excluding nursing home closures
- Total cases transitioned
- Closures per 100 new referrals
- Transitions per 100 new referrals
Andrea Fanelli’s Story

More than 1 in 5 American adults experience chronic pain (Yong et al., 2021), and unfortunately Andrea Fanelli is one of them. For years she dealt with pain brought on by scoliosis, osteoporosis, and psoriatic arthritis. To make matters worse, she was unable to take medication for the psoriatic arthritis due to previous medical issues. Understandably, being in constant pain led Andrea to fall into a deep depression that also turned into anorexia. She lost weight rapidly, felt hopeless, and even stopped seeing her doctors. Andrea eventually agreed with her daughter and doctor that living in a nursing facility would allow her the attention, encouragement and time she needed to save her life.

The move happened on January 10th, 2018, and Andrea remembers it like it was yesterday. She mostly kept to herself as she was still depressed and lacked the motivation to socialize. The loss of independence and privacy was hard to get used to, as was the fact that she could never truly find peace and quiet. Down the road when the pandemic started, she felt more isolated than ever. For her own safety and others, she had to quarantine in her room most days and had very limited social interactions.

Eventually, Andrea began to make friends and even became close with a few special staff members. While working with a dietician, she started to work on her battle with anorexia. She was so thankful for her daughter and staff who would bring her home made meals, which she found easier to eat than the facility food. When Andrea was asked what inspired her to get better, she credited a very special man she had met while living there. Although she never anticipated it, he encouraged and inspired her, reminding her why getting healthy was worth it. He wanted her to be able to leave the nursing home and live the way she wanted to, something his health would not allow him to do.

Andrea did just that. She continued eating, getting stronger, and working on her mental health. One day the facility social worker introduced Andrea to the Money Follows the Person (MFP) program, a program that would provide her the assistance she needed to live in the community once again. She was excited and relieved to know she had options, and that MFP staff would be there to help her every step of the way. Her housing coordinator found her a beautiful, accessible apartment in a secure building. Andrea also started receiving personal care assistance (PCA) services 4 hours a day, to help with daily activities. Her PCA helps with cleaning and laundry, cooking, and transportation. Andrea is so grateful for this help, and sees her PCA as much more than just someone that helps her. “She goes above and beyond for me and is a great friend.”

Andrea described how life is different now. “I get to feed the birds and do what I want. I have a view of the courtyard from my apartment. It’s a nice place to sit and enjoy the fresh air, and it’s covered with beautiful flowers and garden plants.” Now in her own home, she is even considering getting a pet, something she could never do in the nursing home. Although Andrea still deals with pain and mental health, she describes herself as having a new will for life, which she certainly does not take for granted.

MFP Demonstration Background

The Money Follows the Person Rebalancing Demonstration, created by Section 6071 of the Deficit Reduction Act of 2005, supports States’ efforts to “rebalance” their long-term support systems, so that individuals can choose where to live and receive services. One of the major objectives of Money Follows the Person (MFP) is “to increase the use of home and community based, rather than institutional, long-term care services.” MFP supports this by offering grantee States an enhanced Federal Medical Assistance Percentage on qualified services. MFP also offers states the flexibility to provide supplemental services, such as assistive technology and enhanced transition services, to assist in successful transitions. States are then expected to reinvest the savings over the cost of institutional services to rebalance their long-term services and supports for older adults and people with disabilities to a community-based orientation.