

CT Money Follows the Person Report

Quarter 4: October 1 - December 31, 2025

UConn Health, Center on Aging

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

MFP Benchmarks

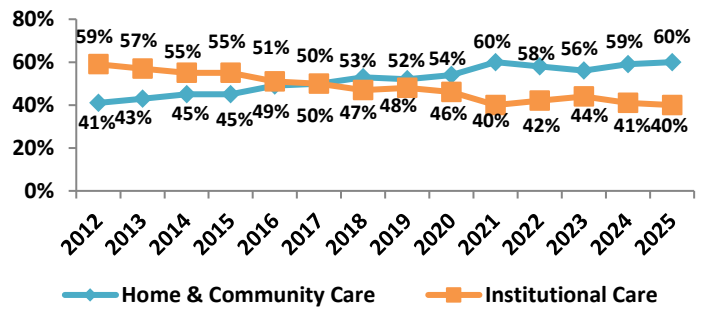
- 1) Transition 5200 people from qualified institutions to the community
- 2) Increase dollars to home and community based services
- 3) Increase hospital discharges to the community rather than to institutions
- 4) Increase probability of returning to the community during the six months following nursing home admission
- 5) Increase the percentage of long term care participants living in the community compared to an institution

Benchmark 1: Total Transitions = 8,803

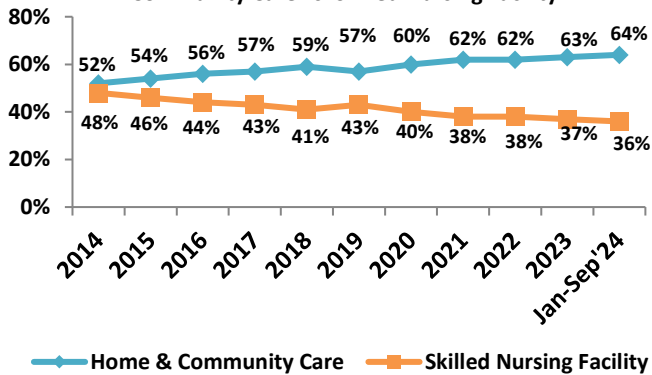
Demonstration = 8,227 (93%)

Non-demonstration = 576 (7%)

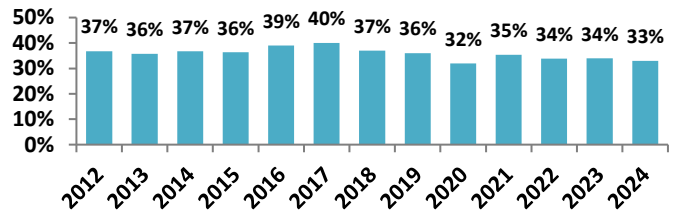
Benchmark 2 CT Medicaid Long-Term Care Expenditures



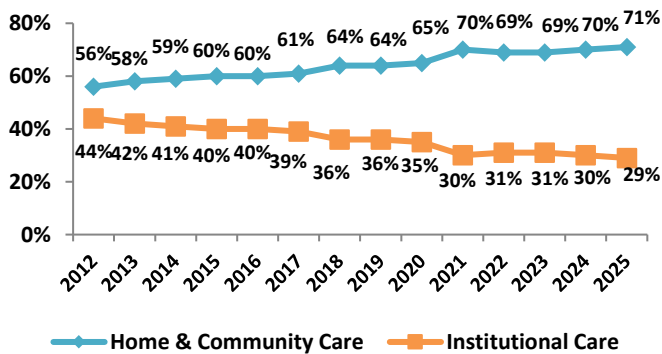
Benchmark 3 Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility



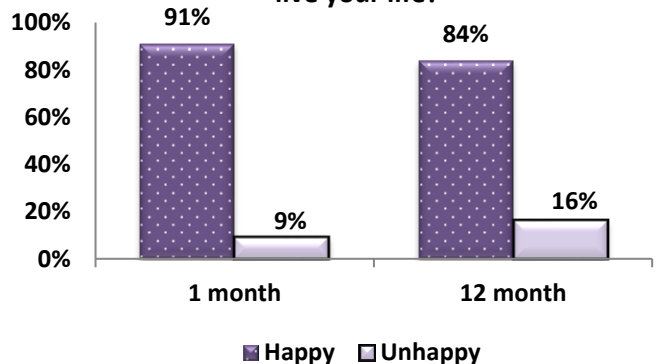
Benchmark 4 Percent of SNF admissions returning to the community within 6 months



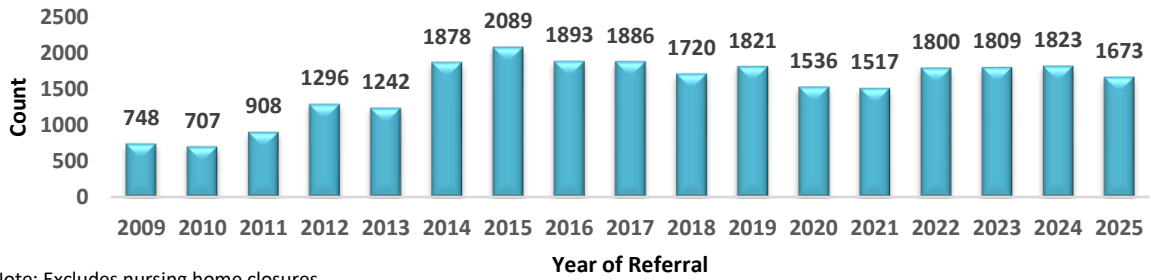
Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions



Are you happy or unhappy with the way you live your life?

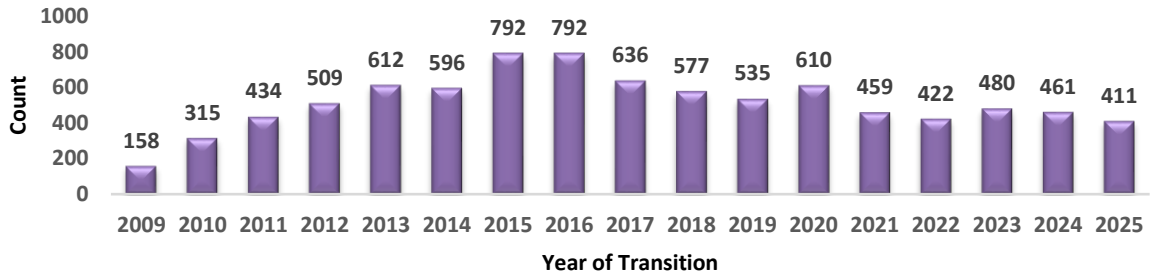


Total Number of Referrals Assigned to the Field by Year

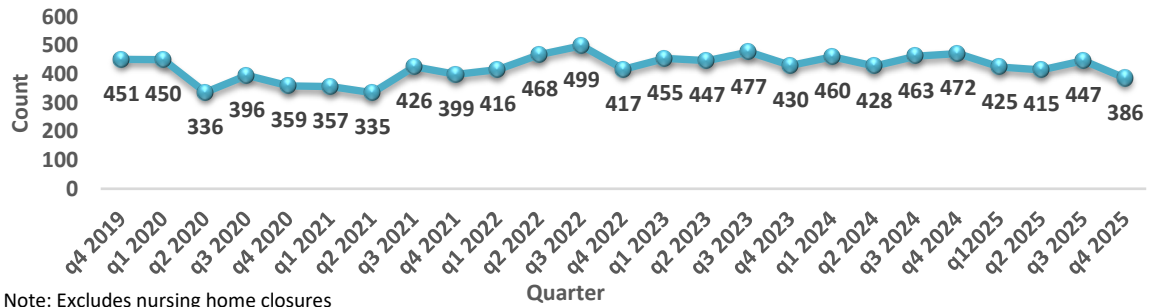


Note: Excludes nursing home closures

Total Number of Transitions by Year

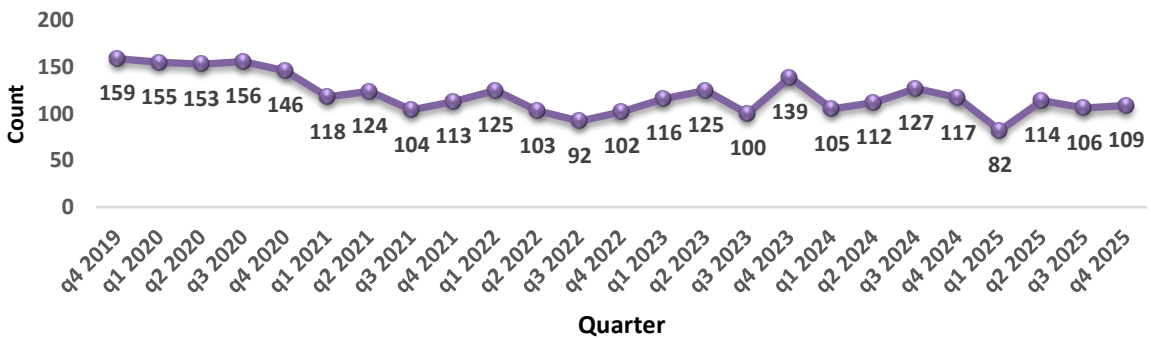


Referrals Assigned to the Field by Quarter

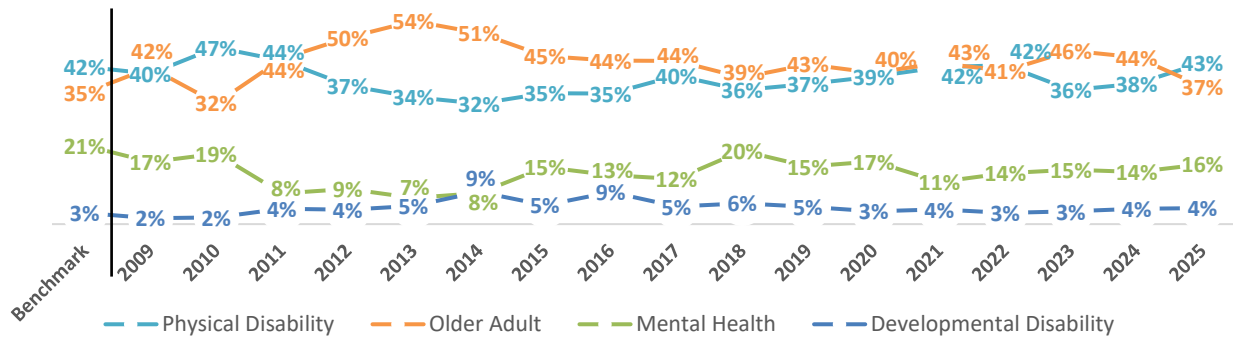


Note: Excludes nursing home closures

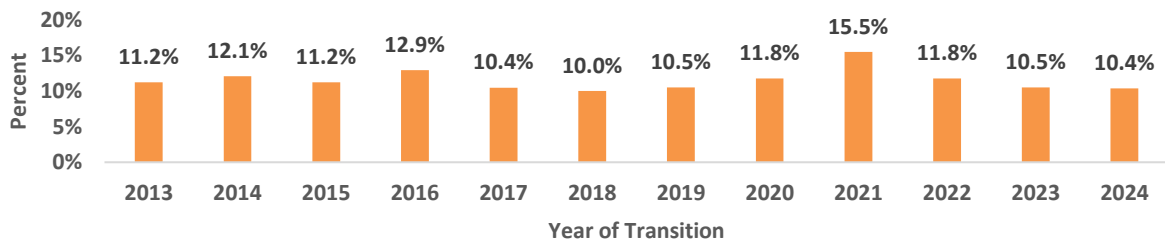
Number of Transitions by Quarter



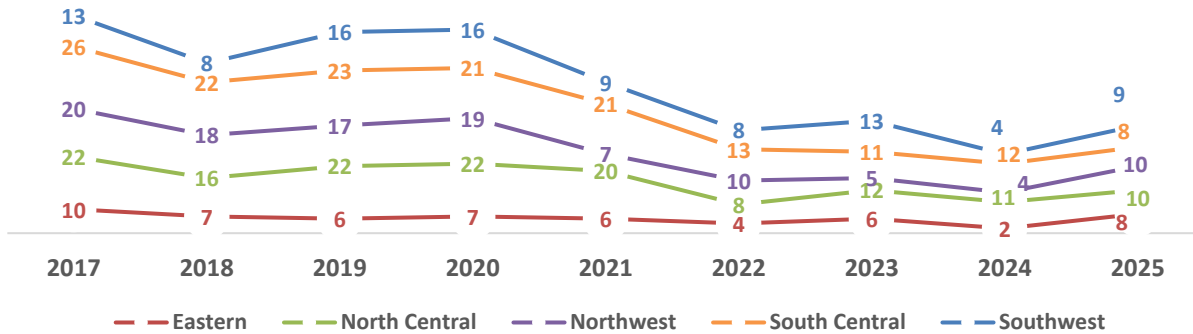
Target Population for Transitions by Year of Transition (Demonstration Only)



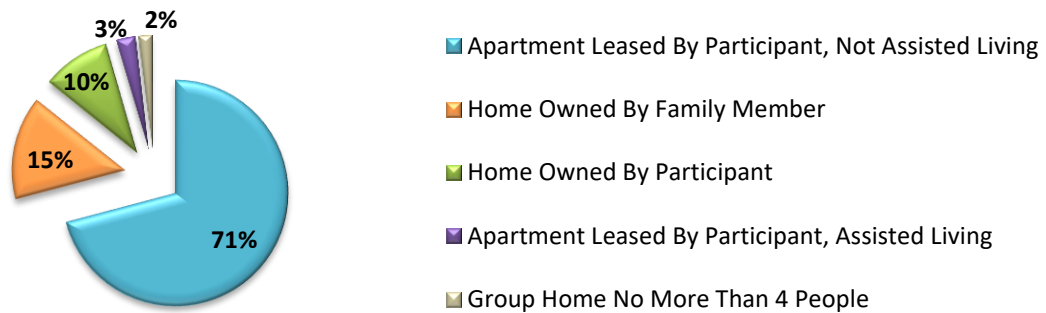
Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay



Number of Participants with Home Modifications by Year Approved and Region

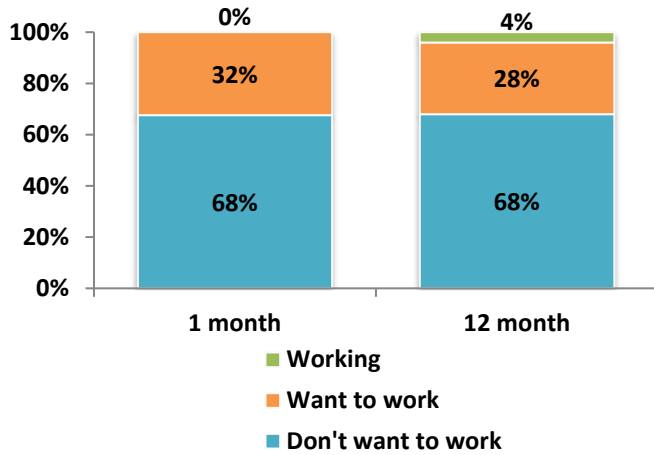


Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 12/31/2025

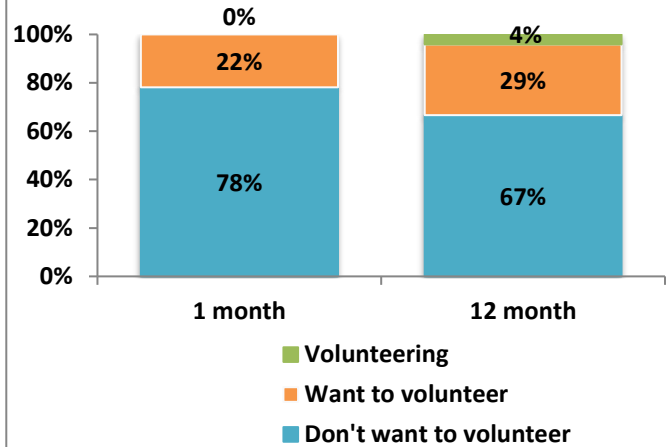


Participants who are Working and/or Volunteering (data 10/1/25-12/31/25)

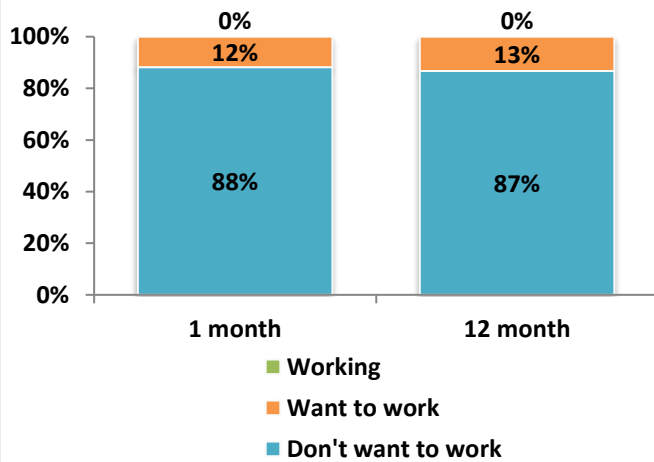
Participants under age 65 who are working and those who would like to work



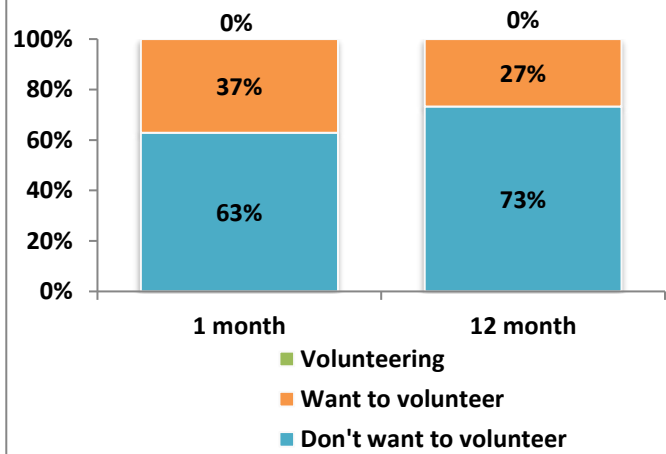
Participants under age 65 who are volunteering and those who would like to volunteer



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

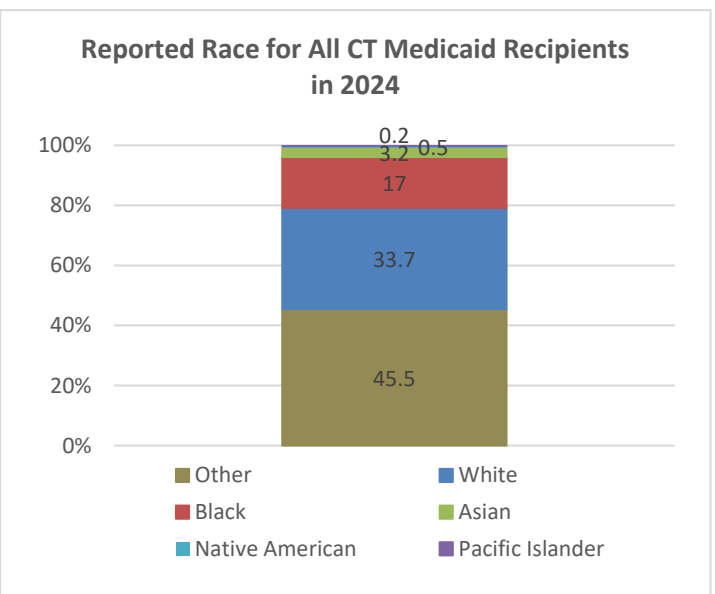
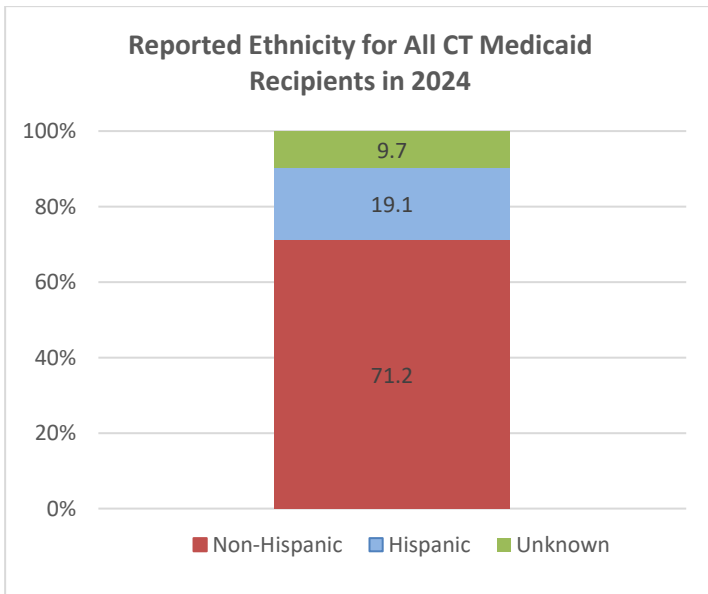
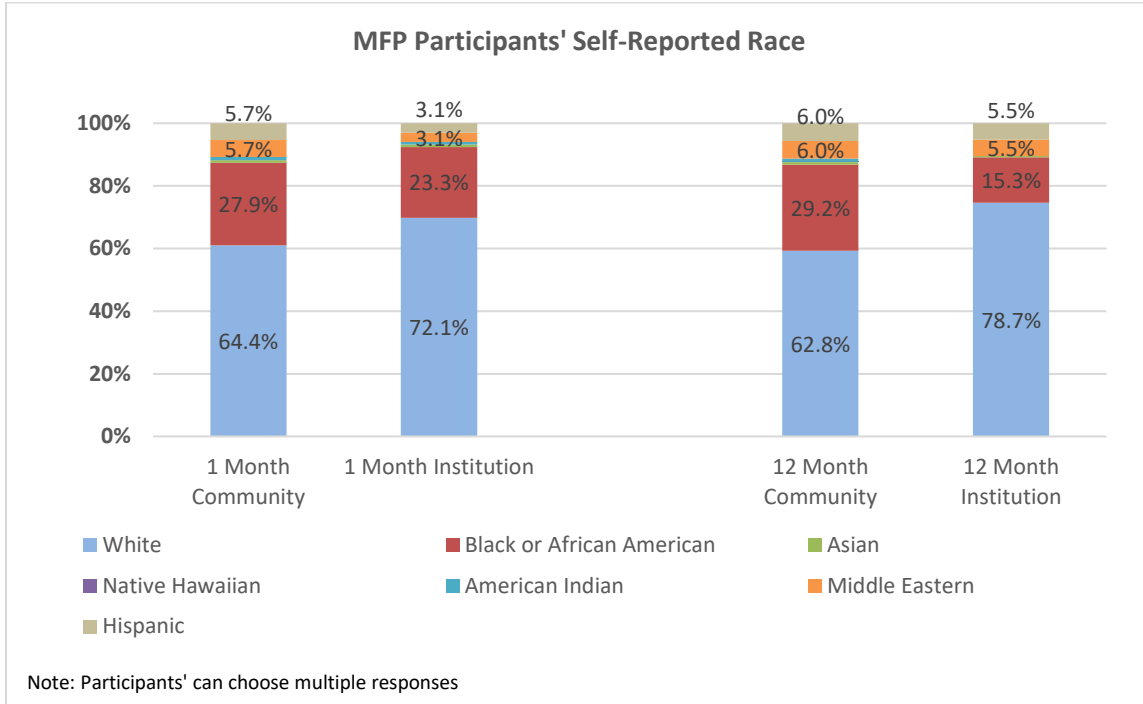


Participants 65 years and older who are volunteering and those who would like to volunteer



Race and Ethnicity for MFP Participants Transitioned 10/1/25 – 12/31/25 and for CT Medicaid Recipients in 2024

Note: MFP participant results are from responses to the HCBS CAHPS MFP Survey race and ethnicity questions.

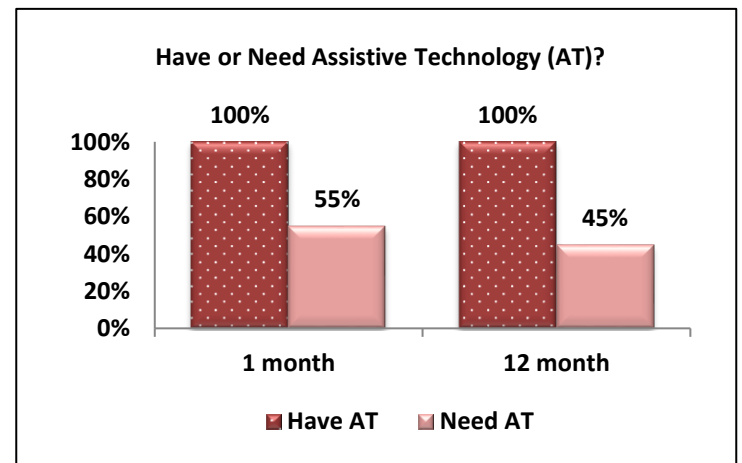
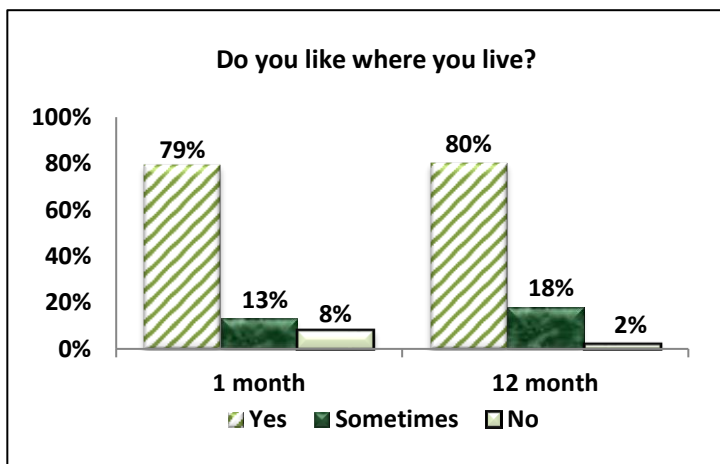
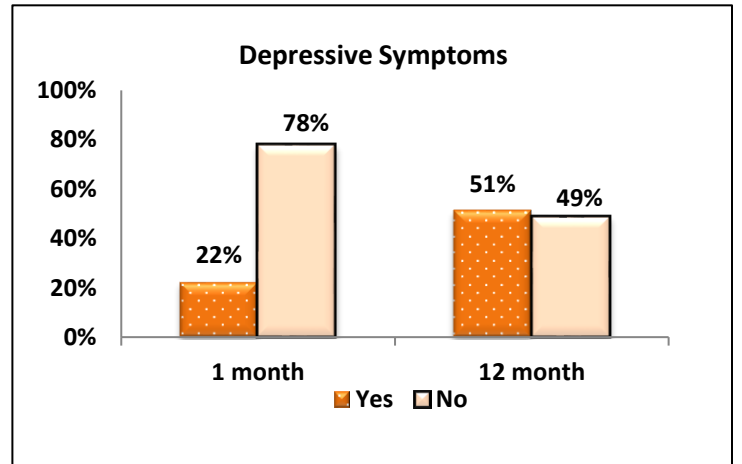
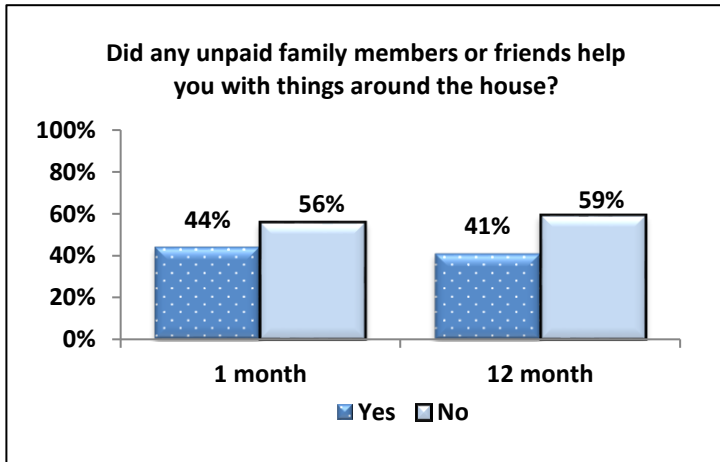
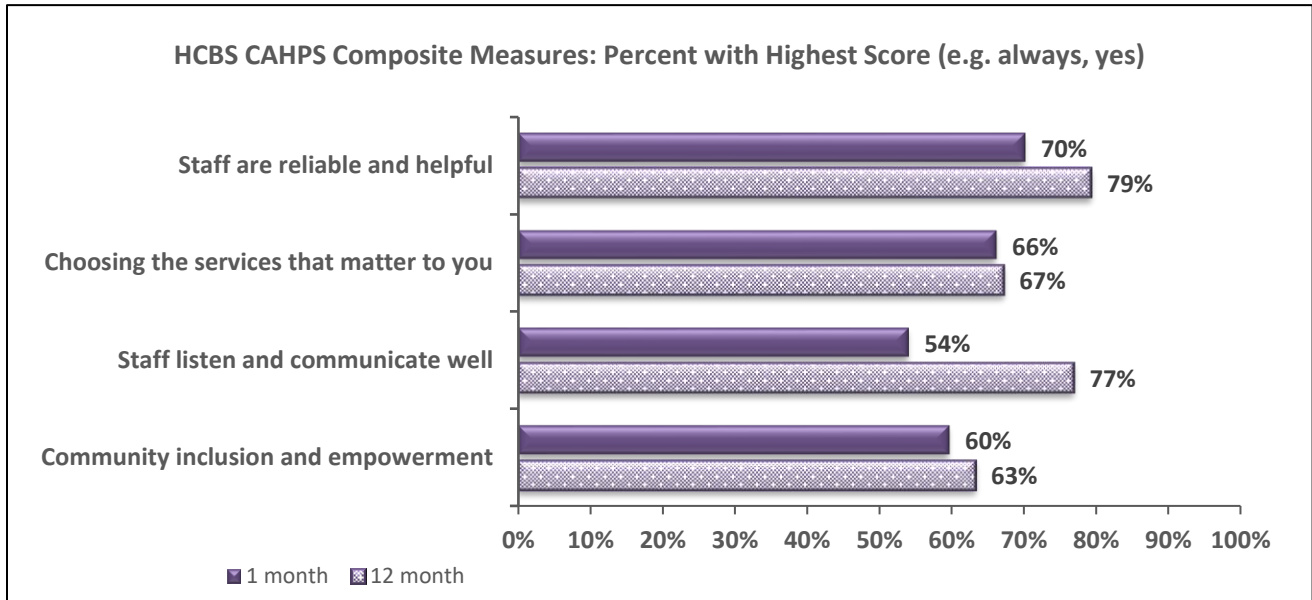


MFP Quality of Life Dashboard

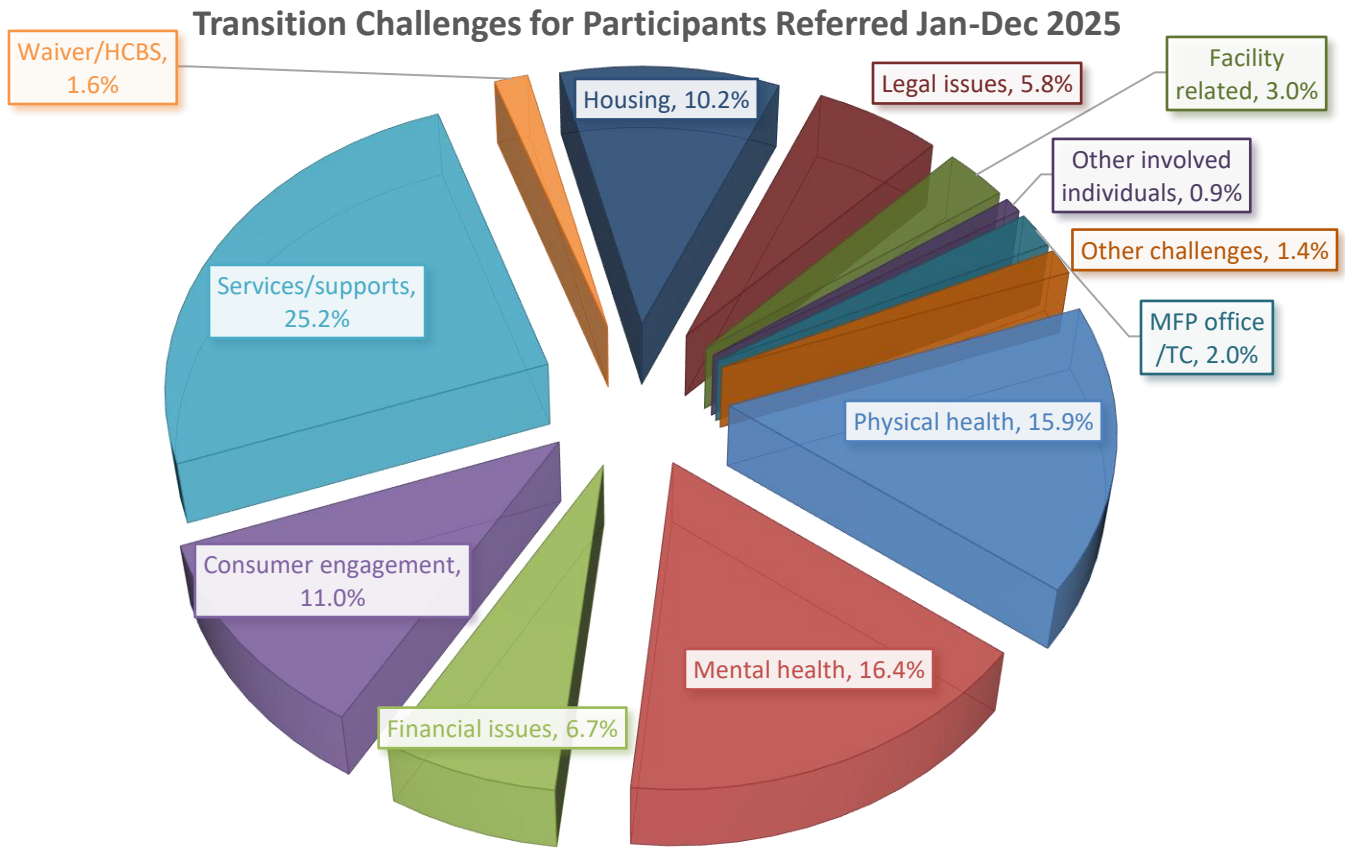
Number of Quality of Life Interviews Completed from 10/1/25 - 12/31/25 (n=124)

1 month interviews done 1 month after transition, n=77

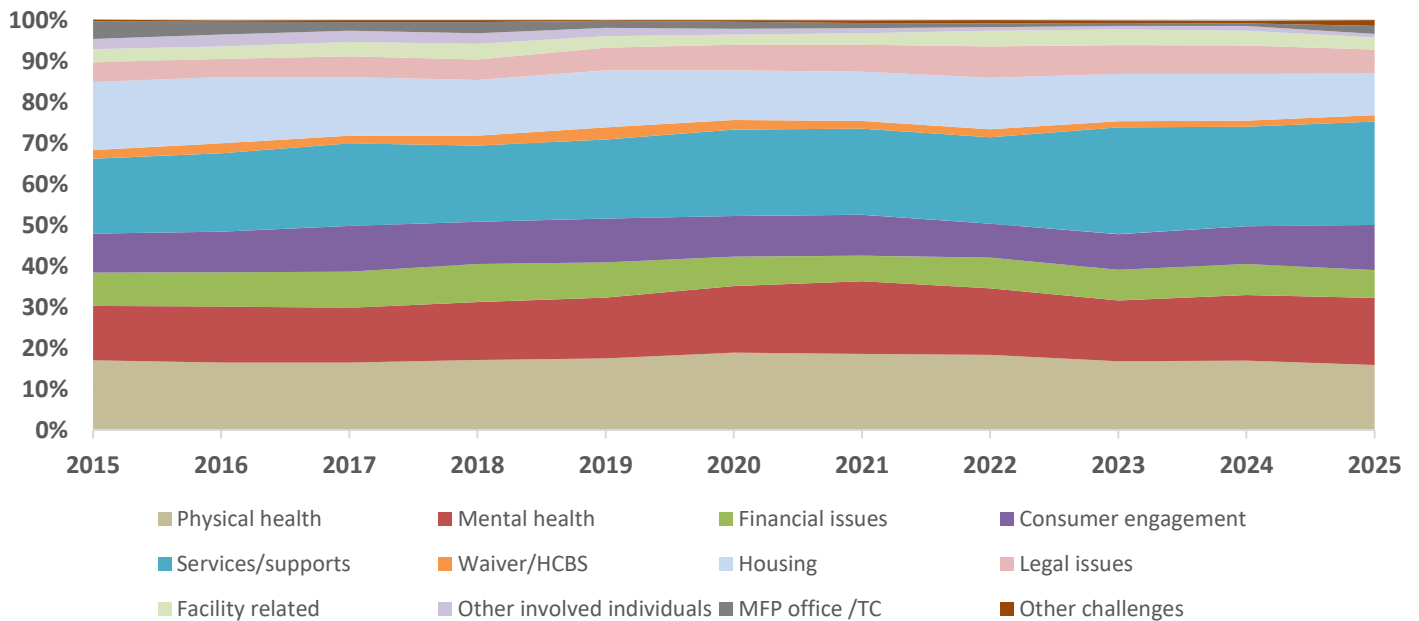
12 month interviews done 12 months after transition, n=47



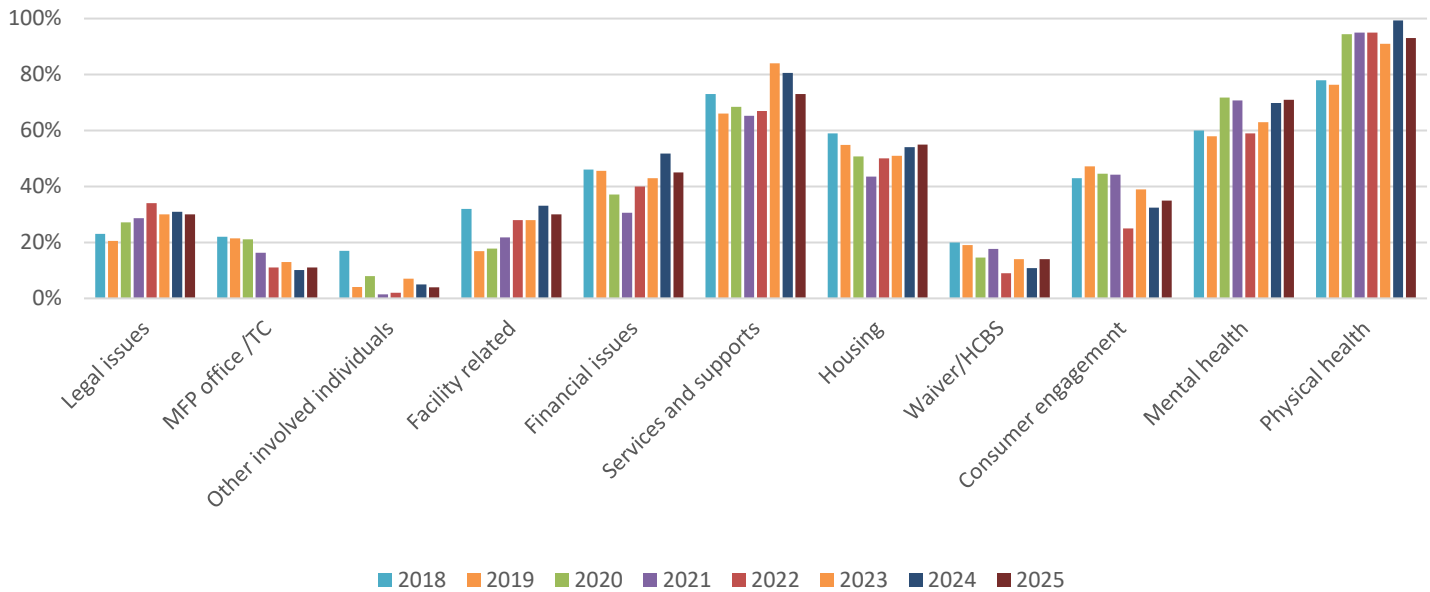
Challenges to Transition as Recorded by TCs and SCMs



Frequency of Transition Challenges by Year of Referral



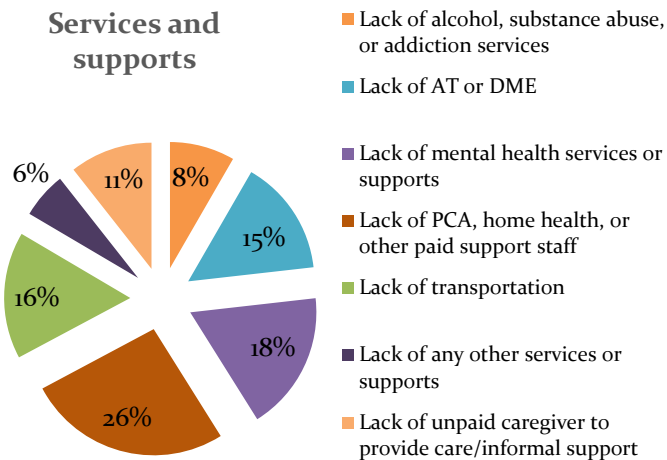
Participants with Each Challenge who Transitioned by Referral Year



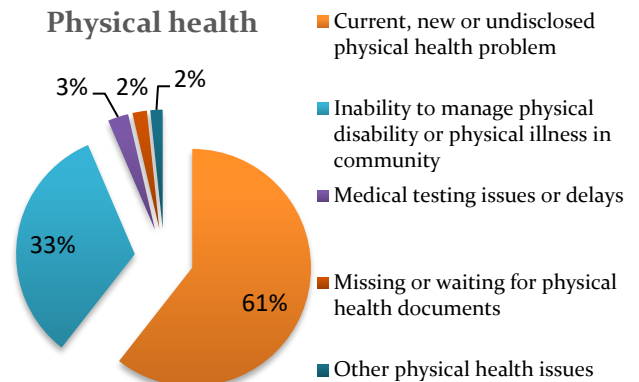
Types of Challenges for Referrals: 1/1/2025 - 12/31/2025

Below are the four most common challenge types for the current timeframe

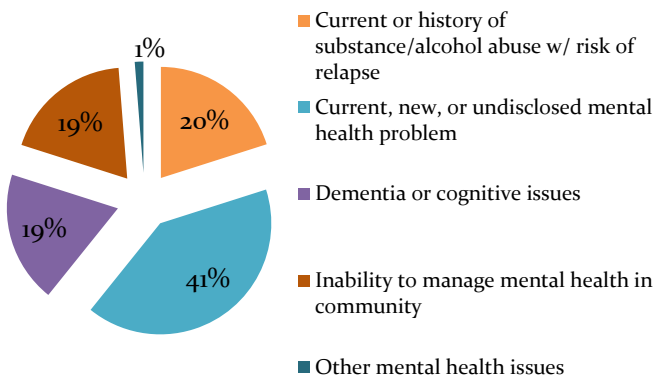
Services and supports



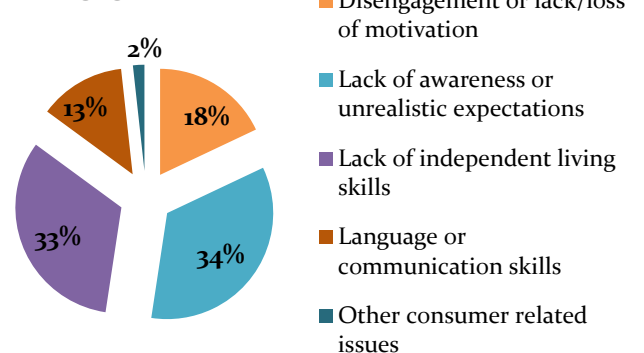
Physical health



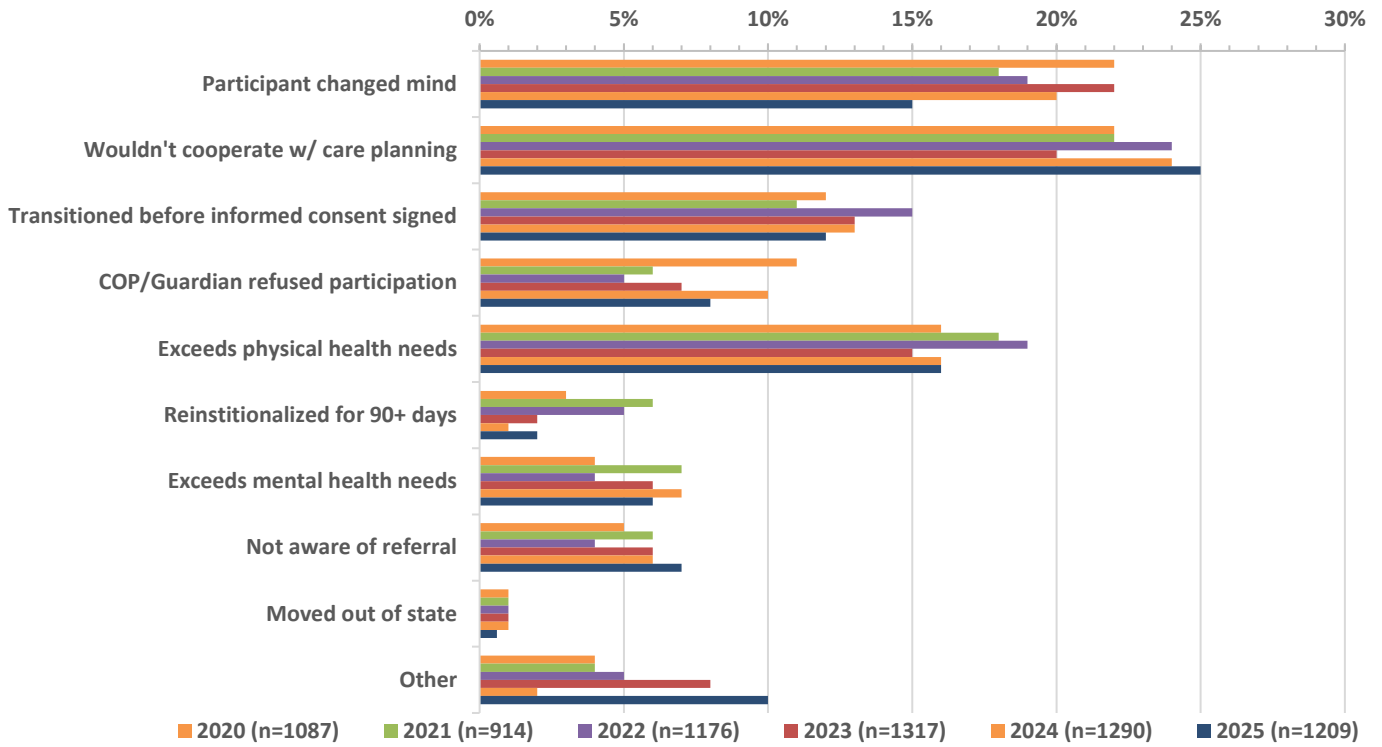
Mental health



Consumer engagement

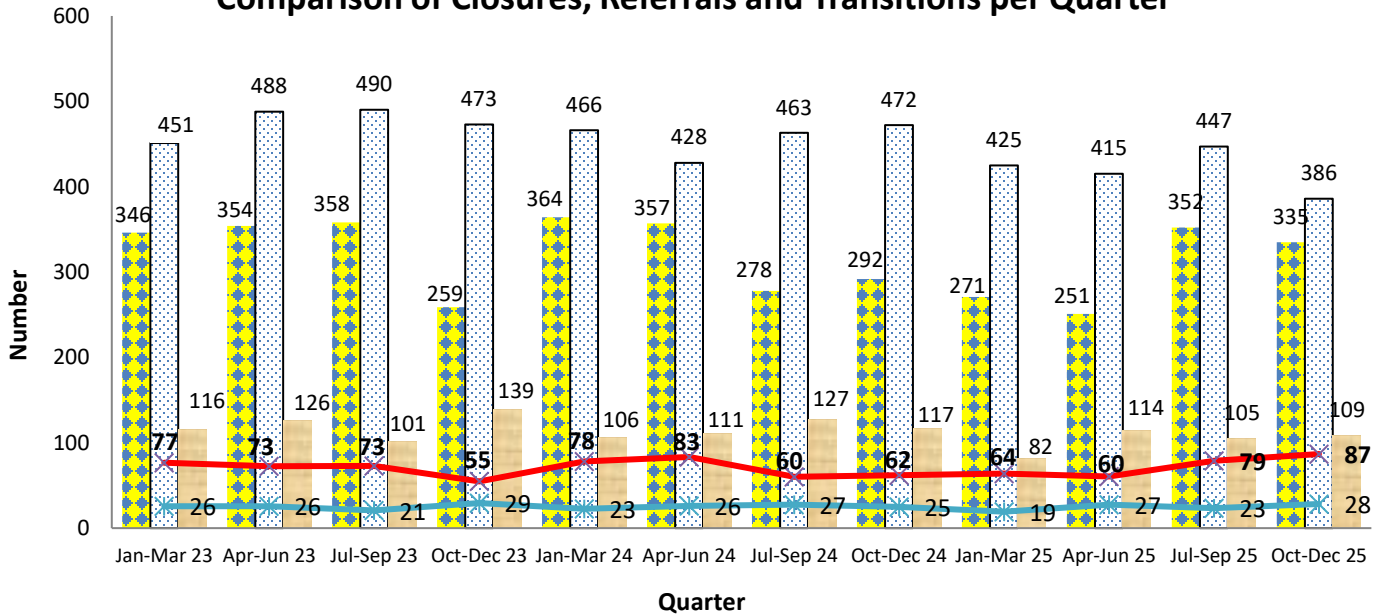


Frequency of Closure Reason by Year of Closure



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
- x— Closures per 100 new referrals
- *— Transitions per 100 new referrals

Julia's Story

On Christmas Day last year, 15-year-old Julia sat on the floor with her brother and opened her gifts. It was a simple moment that many take for granted, but for Julia and her family, it was a perfect depiction of what they had worked so hard for over the last three years.

On Christmas Day three years ago, Julia was living in a hospital receiving around-the-clock care. She was more than six months into a long, grueling recovery from a car accident that claimed her step-father's life and left Julia with massive head trauma. In the hospital, among many procedures, doctors removed a large piece of her skull to allow her brain to swell and placed her into an induced coma. She remained on life support for almost four weeks. The doctors explained to Julia's mother Amanda that they did not know whether Julia would survive and if she did, what kind of state she would be in.

Despite the devastating reality they faced, Julia and her family held onto hope. Amanda watched in gratitude as Julia's body slowly began to heal. She became eligible for a tracheostomy which allowed her to get off life support and begin breathing on her own. From that point on, Amanda describes seeing positive steps forward just about every day. Intensive therapy at the Hospital for Special Care combined with Julia's fierce determination led to dramatic improvements in her physical and cognitive abilities.

Almost exactly three years after the accident, Julia was headed home to a new apartment. It was bittersweet as nurses lined the halls of the Hospital for Special Care and cheered for a young girl they had gotten to know so well. Julia smiled from ear to ear as she had throughout this entire journey. Although Julia and her family had a wonderful experience with the care at the hospital, they could not wait to be together under one roof again.

To aid Julia's transition from a hospital to a community residence, Amanda sought assistance from the Money Follows the Person program. The program provided support to Julia and her family by assisting with finding appropriate housing, coordinating in-home care, coordinating outpatient occupational and physical therapy, and purchasing necessary supplies and equipment like a specialized wheelchair, hospital bed, and communication tablet. Amanda's current partner became a paid PCA for Julia which helps greatly, as Julia still needs constant supervision.

Today Julia is living life very much like other teenage girls. She participates in unified dance and cheerleading, hangs out with friends, and "gives her mom a hard time!" With her communication tablet, Julia described her fondness for her new boyfriend at school, Kole. She is back together with her biggest cheerleader (her younger brother) and has her own private room. Julia's mobility continues to improve every day and she can now stand and pivot on her own. Amanda knows she will soon watch her daughter take those first steps for a second time in her life.



Photo credit: Sarah Driscoll

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.