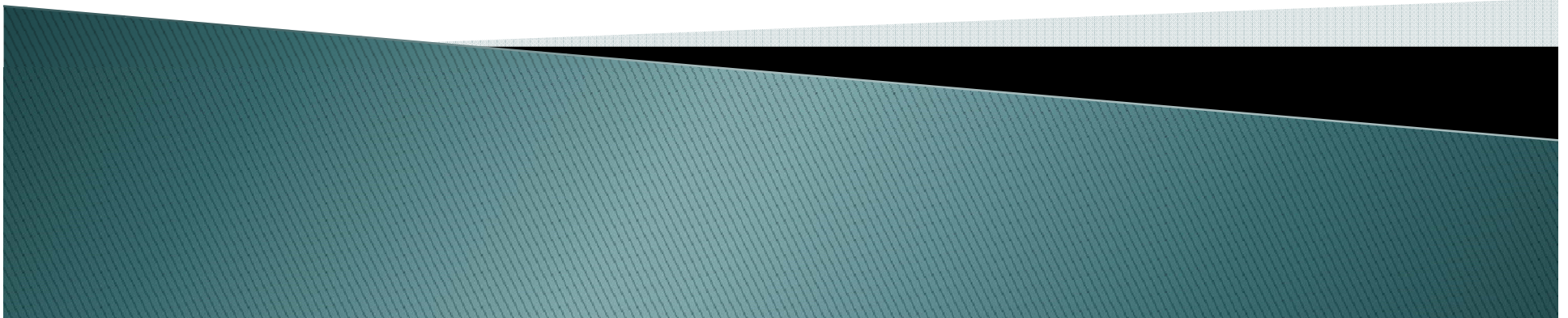


Presentation for

Connecticut Regional Institute for the 21st Century

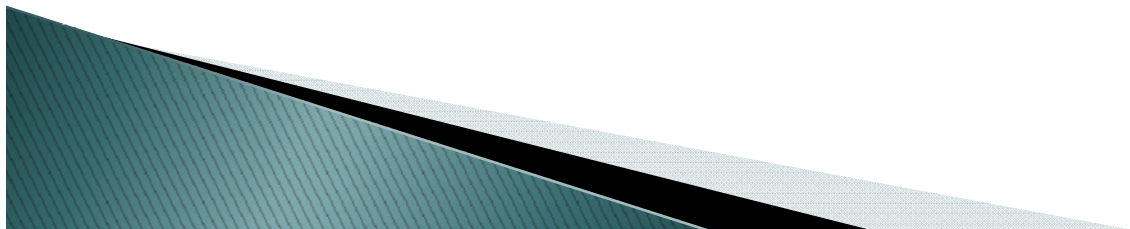
Assessment of Connecticut's Long-Term Care System March 8, 2010

BlumShapiro
Accounting Tax Business Consulting



Contents

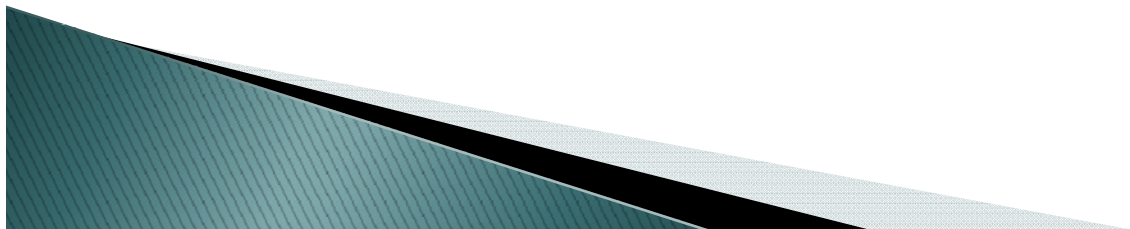
- ▶ Project Background and Approach
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Background

The Connecticut Regional Institute for the 21st Century (CRI) has conducted research on a number of important state public policy issues and published results to provide information and recommendations that generate discussion and action that enhance the state's overall competitiveness.

CRI retained BlumShapiro to report on the long-term care system in the State of Connecticut. As agreed upon with CRI, BlumShapiro has followed the approach described on the next page and is pleased to provide this report as a result of our work.



Approach



BlumShapiro performed extensive research of existing studies and work performed on long-term care. This research was validated by performing interviews with as many key long-term care stakeholders that agreed to be interviewed. The interviews provided a better understanding of the many different stakeholders and perspectives that effect the long-term care system in Connecticut. This research was used to develop findings and recommendations that could be used to improve the long-term care system in Connecticut.

Referenced Literature

BlumShapiro reviewed an extensive set of literature to perform this assessment. Below are the major works we reference in this report. The list of research literature evaluated by Blum Shapiro is long and extensive and located at the end of this document.

- ▶ Connecticut Long Term Care Advisory Council, *Legislative Update*, February 5, 2010.
- ▶ Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010.
- ▶ University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007.
- ▶ University of Connecticut Health Center's Center on Aging, *Long Term Care Needs Assessment Legislative Briefing – Follow-up to Questions Asked*, January 16, 2008.
- ▶ Connecticut Department of Social Services, *Money Follows the Person Rebalancing Demonstration Legislative Status Update*, October 2009.
- ▶ Source: Connecticut Commission on Aging, *Break Down the Silos – Streamline the Home & Community Based System*, December 9, 2009.
- ▶ Washington State Department of Social and Health Services, *Fact Sheet – A Successful Vision*, December 2009
<http://www.aasa.dshs.wa.gov/about/factsheets/default.asp>
- ▶ AARP Public Policy Institute, *A Balancing Act: State Long-Term Care Reform*, July 2008, Oregon.
- ▶ AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

Interviews

- ▶ David Guttchen, Chair of Connecticut LTC Planning Committee, OPM
- ▶ Dr. Julie Robison, UCONN Health Center's Center on Aging
- ▶ Noreen Shugrue, UCONN Health Center's Center on Aging
- ▶ Julia Evans Starr, Executive Director, CT Commission on Aging
- ▶ Debra Polun, Legislative Director, CT Commission on Aging
- ▶ Mag Morelli, President, Connecticut Association of Not-for-profit For The Aging
- ▶ Matthew V. Barrett, Executive Vice-President, CT Association of Health Care Facilities
- ▶ Brian Ellsworth, President, CT Association for Home Care and Hospice
- ▶ Bill Cibes, Former Director of OPM
- ▶ Brenda Kelly, State Director, AARP
- ▶ Claudio Gualtieri, Program Coordinator, AARP
- ▶ Dawn Lambert, Money Follows the Person (MFP), CT Department of Social Services
- ▶ Marc Ryan, Former OPM
- ▶ Lorraine Aronson, Former CFO UCONN
- ▶ Senator Jonathan Harris, Public Health Committee

Long-term Care is Broad and Affects Everyone

- ▶ Long-term care (LTC) refers to a broad range of paid and unpaid supportive services for persons who need assistance due to a physical, cognitive or mental disability or condition. LTC consists largely of personal assistance with the routine tasks of life as well as additional activities necessary for living independently. Unlike medical care where the goal is to cure or control an illness, the goal of LTC is to allow an individual to attain and maintain the highest reasonable level of functioning in the course of everyday activities and to contribute to independent living.
- ▶ Long-term care will affect all of us at some point in our lives. Whether it is because we need services and support ourselves, or we are providing care for someone in need, regardless of age, health or wealth, it is unlikely that we will be able to escape the issue of LTC.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, page 2.

Providers of Long-term Care

- ▶ Informal/unpaid home and community care is the largest provider of long-term care.

Long-term Care in Connecticut in 2006

Providers	With state Medicaid	Without state Medicaid	Total Residents
Receiving care in nursing homes	18,700	9,000	27,700
Receiving care in the Community (formal/paid)	21,300	116,000	137,300
Receiving care in the Community (informal/unpaid)	N/A	200,000	200,000
Total	40,000	325,000	365,000

Source: Connecticut Long Term Care Advisory Council,
Legislative Update, February 5, 2010.

Providers of Long-term Care

► Families/Informal Caregivers

- Informal caregivers are family and friends who provide care without pay, and are the primary source of long-term care. There are an estimated 44 million informal caregivers in the United States. The importance of unpaid care provided by family and friends cannot be overemphasized, as it constitutes the backbone of the long-term care system. The total estimated annual economic value of unpaid care to people with disabilities age 18 and older in 2004 was \$306 billion. This figure exceeds public expenditures for formal health care (\$43 billion in 2004) and nursing home care (\$115 billion in 2004).

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 6.

► Formal Caregivers

- Defined as paid direct providers of LTC services in a home, community-based or institutional setting.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 7.

- Home and Community-Based Care (HCBS) encompasses home care, adult day care, respite, community housing options, transportation, personal assistants, assistive technology and employment services.
- Institutional Care includes nursing facilities, intermediate care facilities for people with mental retardation (ICF/MRs), psychiatric hospitals and chronic disease hospitals.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 3.

Sources of Long-term Care Financing

- ▶ Medicaid is the primary payer of LTC nationally and in Connecticut.
- ▶ Medicare does not generally pay for long-term care, with minor exceptions – it will pay for 100 days post-hospital discharge in a nursing home and for very limited home care services. Medicare coverage is focused on rehabilitation.

Top Financing Sources (US 2004)	Percent (%)
Medicaid	42%
Out-of-pocket by individuals	23%
Medicare	20%
Private insurance	9%
Other public sources	3%
All other	3%
Total	100%

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 13.

Sources of Long-term Care Financing

- ▶ Historically, Medicaid did not pay for long term care in the community except by waiver, hence it is “institutionally biased”.
- ▶ Individuals paid for nearly one-quarter of long-term care costs in 2004, including direct payment of services as well as deductibles and co-payments for services primarily paid by another source.
- ▶ Over the past 10 years, the market for long-term care insurance has grown substantially. In 1990, slightly fewer than 2 million policies had been sold in the U.S. to individuals age 55 and older. By 2000, however, this figure had tripled and the number of policies sold either on an individual basis or through employer-sponsored group plans had increased to more than six million.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 13.

Connecticut Medicaid Expenditures are Significant

- ▶ In SFY 2009, the Connecticut Medicaid program spent \$2,498 million on long-term care. These Medicaid long-term care expenses account for 53% of all Medicaid spending and 13% of total expenditures for the State of Connecticut.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 37.

Connecticut Medicaid LTC Clients and Expenditures SFY 2009

	SFY 2009 Medicaid LTC Clients Monthly Average	SFY 2009 Medicaid LTC Expenditures (millions)
Community-based Care	21,275 (53%)	\$ 886 (35.5%)
Institutional Care	18,822 (47%)	\$1,612 (64.5%)
Total	40,097 (100%)	\$2,498 (100.0%)

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 45, Table 8

- ▶ These costs do not include private financing and informal care and other services and supports for adults with psychiatric disabilities funded by the Department of Mental Health and Addiction Services.
- ▶ This \$2,498 million is offset 50% by federal funds. The net cost of Medicaid LTC to Connecticut is about \$1,249 million.

The Demand for Medicaid in Connecticut is Growing

- ▶ In Connecticut over the next 15 years (2010 to 2025), the total population is projected to increase 3%. Although this increase in population is modest there are 2 extraordinary trends:
 - The number of adults between the ages of 18 and 64 will actually decrease by 5%. These are the primary people who provide formal and informal care in the LTC system.
 - The number people over 65 years of age will increase by 40% (207,745), due to the aging of the baby boom generation.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 42, Table 5.

- Projections of future demand for long-term care services based on population growth indicate that total demand for ages 40+ will increase by nearly 30% by 2030, with far higher percentage increases among the older age groups.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 5.

- ▶ The increasing population of 65+ years of age residents and the reduction of the age group that can provide care will drive a significant increase in demand for LTC in Connecticut.

Medicaid Expenditures in Connecticut are Growing

Projections of Connecticut Medicaid Long-Term Care Expenditures by Current Client Ratios of Community and Institutional Care SFY 2009 and SFY 2025

	Current Client Ratio	2025 Expenditures with Current Client Ratio (millions)	Increase from 2009 to 2025 (millions)
Community-Based Care	53%	\$2,073	\$1,188
Institutional Care	47%	\$3,774	\$2,162
Total	100%	\$5,847	\$3,350

Note: Expenditure projections include 5% annual compound rate of increase.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 48, Table 11.

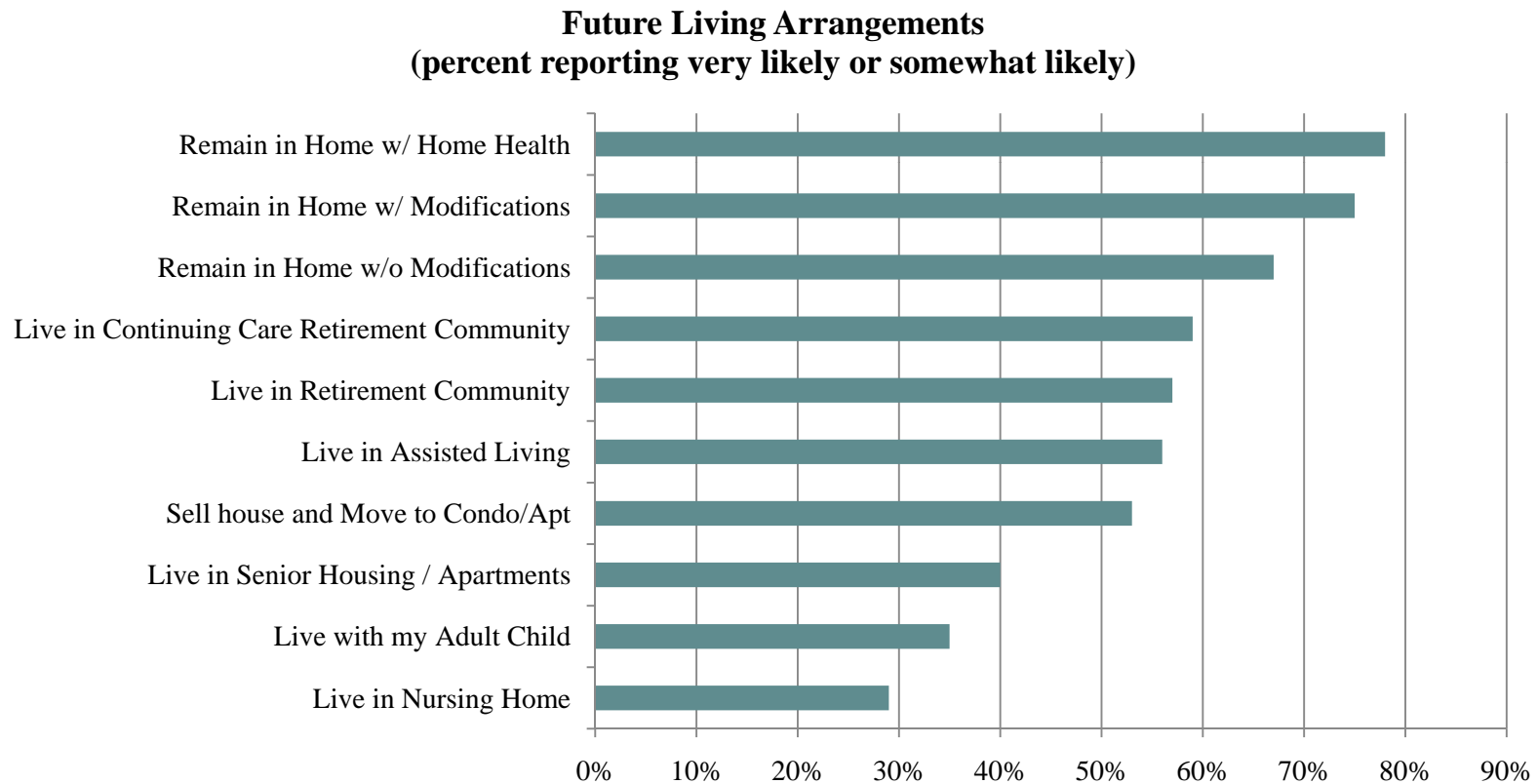
The Current System is Out of Balance.

- ▶ Connecticut's Long-term care system has many positive elements and has made great strides over the last several years in providing choices and options for older adults and individuals with disabilities. Despite these gains, the system is still fundamentally out of balance in two important areas.
 1. Balancing the ratio of HCBS and Institutional Care – Traditionally, in Connecticut and nationwide, Medicaid has made access to institutional care easier than to home and community-based care. Largely, this is a result of federal Medicaid rules and regulations. Consequently, the ratio between care and support provided in the home and the community and those provided in institutions has consistently been out of balance and skewed towards institutional care.
 2. Balancing the ratio of public and private resources – The second area of imbalance involves the resources spent on long-term care services and supports. The lack of Medicare and health insurance coverage for long-term care, combined with the lack of planning, has created a long-term care financing system that is overly reliant on the Medicaid program. Medicaid, by default, has become the primary public program for long-term care. However, in order to access Medicaid, individuals must first impoverish themselves. Therefore, we have a system that requires individuals to spend all their savings first in order to receive government support for their ongoing needs.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 3,4.

Connecticut's Residents Prefer to Receive Long-term Care in their Home

- ▶ Almost 80% of people would like to continue living in their homes with home health or homemaker services provided at home.



Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 17, Figure 7.

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HCBS Have a Lower Average Cost to Connecticut

- ▶ On average, Medicaid dollars can support more than two older people and adults with physical disabilities in a home and community based setting for every person in an institutional setting.
 - \$32,902 – the SFY 2006 average cost per client for HCBS.
 - \$74,637 – the SFY 2006 average cost per client for institutional care

Source: University of Connecticut Health Center's Center on Aging, *Long Term Care Needs Assessment Legislative Briefing – Follow-up to Questions Asked*, January 16, 2008, Question 2.

- ▶ There are various estimates for the average cost depending upon the year, state, etc. However, they do agree that home based care is about 50% of the cost of institutional care.
- ▶ There are additional costs related to HCBS for room and board that are borne by the recipient or other state and federal programs. These costs are included in the institutional average.
- ▶ The average costs do not take acuity into account.

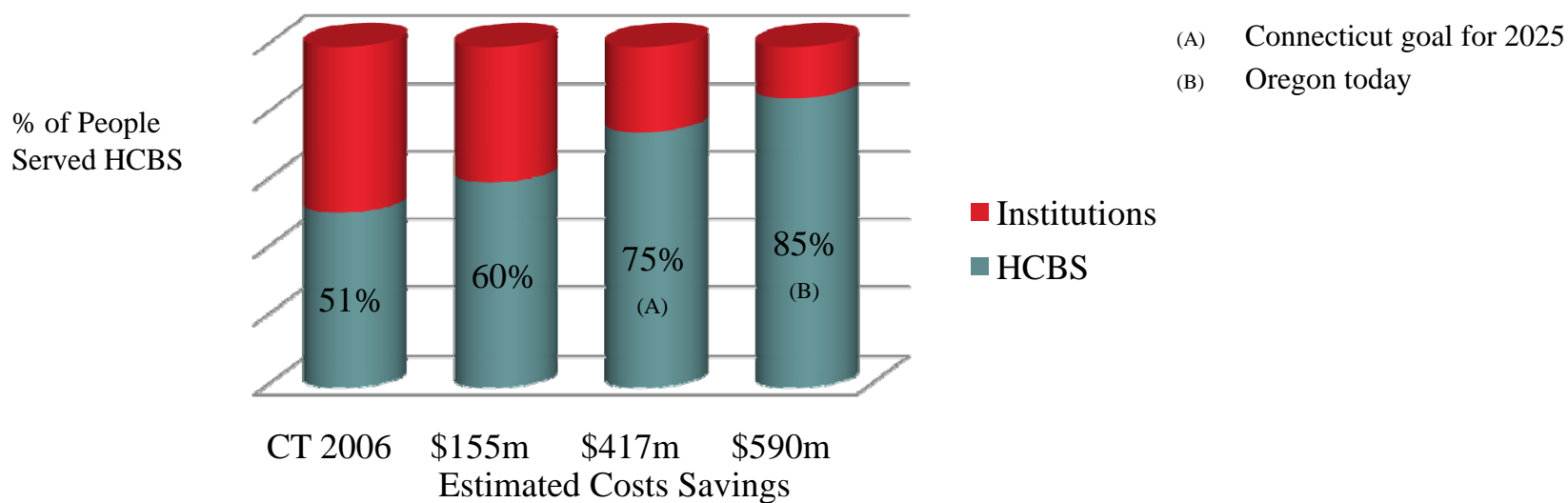
Benefits of Rebalancing

- ▶ Rebalancing provides residents more
 - choice,
 - parity among groups,
 - access,
 - efficiency and
 - quality.

- ▶ Constituent preferences align with fiscal savings.

Source: Connecticut Long Term Care Advisory Council,
Legislative Update, February 5, 2010.

Benefits of Rebalancing



Source: University of Connecticut Health Center's Center on Aging, *Long Term Care Needs Assessment Legislative Briefing – Follow-up to Questions Asked*, January 16, 2008, Question 2.

Rebalancing can Slow Growth of LTC Spending

- ▶ The number people in Connecticut over 65 years of age will increase by 40% in the next 15 years significantly increasing demand for LTC
- ▶ Total future costs and institutional care costs will both increase even with rebalancing
- ▶ Rebalancing significantly avoids costs in the future

Projections of Connecticut Medicaid Long-Term Care Expenditures by Current and optimal Client Ratios of Community and Institutional Care SFY 2009 and SFY 2025.

	Current Client Ratio SFY 2009	SFY 2009 Actual Expenditures (millions)	2025 Expenditures with Current Client Ratio (millions)	Increase from 2009 to 2025 (millions)	Optimal Client Ratio (A)	2025 Expenditures with Optimal Client Ratio (millions)	Increase from 2009 to 2025 (millions)
Community-based Care	53%	\$ 886	\$2,073	\$1,188	75%	\$2,930	\$2,045
Institutional Care	47%	\$1,612	\$3,774	\$2,162	25%	\$2,010	\$398
Total		\$2,498	\$5,847	\$3,350		\$4,940	\$2,443

**\$900 million
Annual Cost Avoidance**

(A) Connecticut goal.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 48, Table 11.

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Connecticut is Behind other States

- ▶ Home and Community Based Care Services (HCBS) expenditures in Connecticut were 35.5% of total LTC expenditures in FY 2007 and are still 35.5% in SFY 2009.
- ▶ The US HCBS care % national average of LTC expenditures is 42% and increases about 1-3% per year.
- ▶ Connecticut ranks 34th among the states and is below the national average.

**Percent of Medicaid LTC Spending
for HCBS FY 2007**

State	Percent	U.S. Rank
New Mexico	72.9	1
Oregon	72.7	2
Arizona	64.0	3
Maine	51.4	11
Rhode Island	45.6	14
U.S.	41.7	-
New Hampshire	39.6	25
Massachusetts	38.7	28
Connecticut	35.5	34

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 46, Table 9

Rebalancing is Difficult

– Fractured Governance

- ▶ Connecticut has a fractured governance structure for providing long-term care that requires high levels of coordination between many state departments and groups.

Major Connecticut Agencies

- ▶ Department of Social Services (DSS)
- ▶ Department of Developmental Services (DDS) – formerly Department of Mental Retardation (DMR)
- ▶ Long-Term care Ombudsman Program (LTCOP) – independent office under DSS
- ▶ Department of Mental Health and Addiction Services (DMHAS)
- ▶ Department of Public Health (DPH)
- ▶ Proposal for New Department on Aging (PA 05-280)

Other Connecticut Agencies

- ▶ Office of Policy and Management (OPM)
- ▶ The Connecticut Commission on Aging (COA)
- ▶ Department of Economic and Community Development (DECD)
- ▶ Department of Transportation (DOT)
- ▶ Department of Children and Families (DCF)
- ▶ Office of Protection and Advocacy for Persons with Disabilities (P&A)
- ▶ Board of Education and Services for the Blind (BESB)
- ▶ Commission on the Deaf and Hearing Impaired (CDHI)
- ▶ Department of Veterans' Affairs (DVA)

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, Part II, pp 8-12.

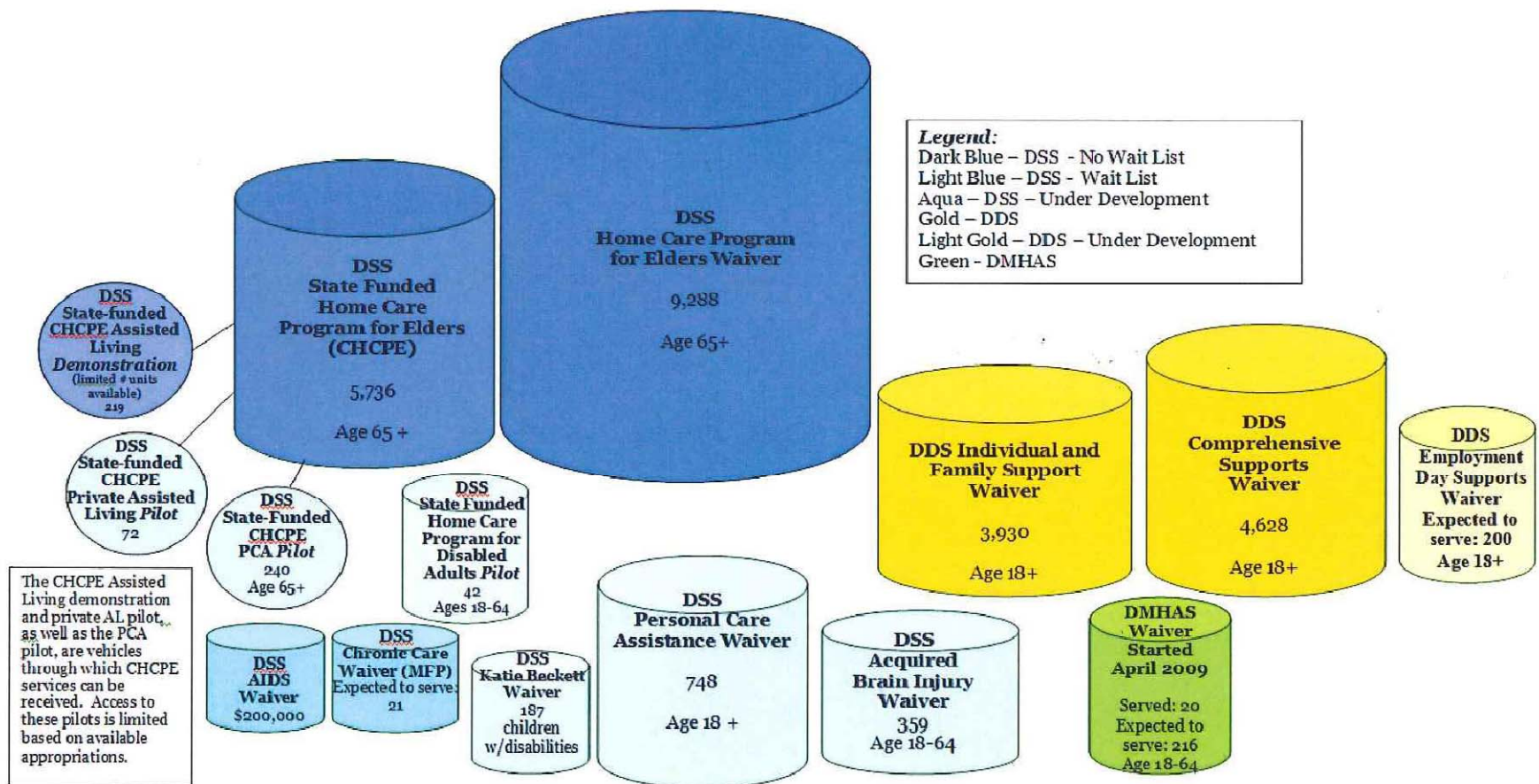
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Rebalancing is Difficult

- ▶ The Federal Medicaid program was developed and implemented when institutions were the only real care alternative. As such, Medicaid was created to enable people to get institutional care as easily as possible.
- ▶ With the growing preference, availability, and cost of HCBS for LTC there have been adjustments to Medicaid, called 'waivers', created to enable HCBS for people with very specific types of disabilities.
- ▶ LTC waivers in Connecticut are each separately managed and implemented creating a very challenging environment for persons seeking to learn about their LTC options and then acquire HCBS when appropriate.
- ▶ Implementation of rebalancing requires improvement in the ability of people to acquire HCBS at a level that is on par with institutional care so that people have a choice when HCBS is an appropriate option.

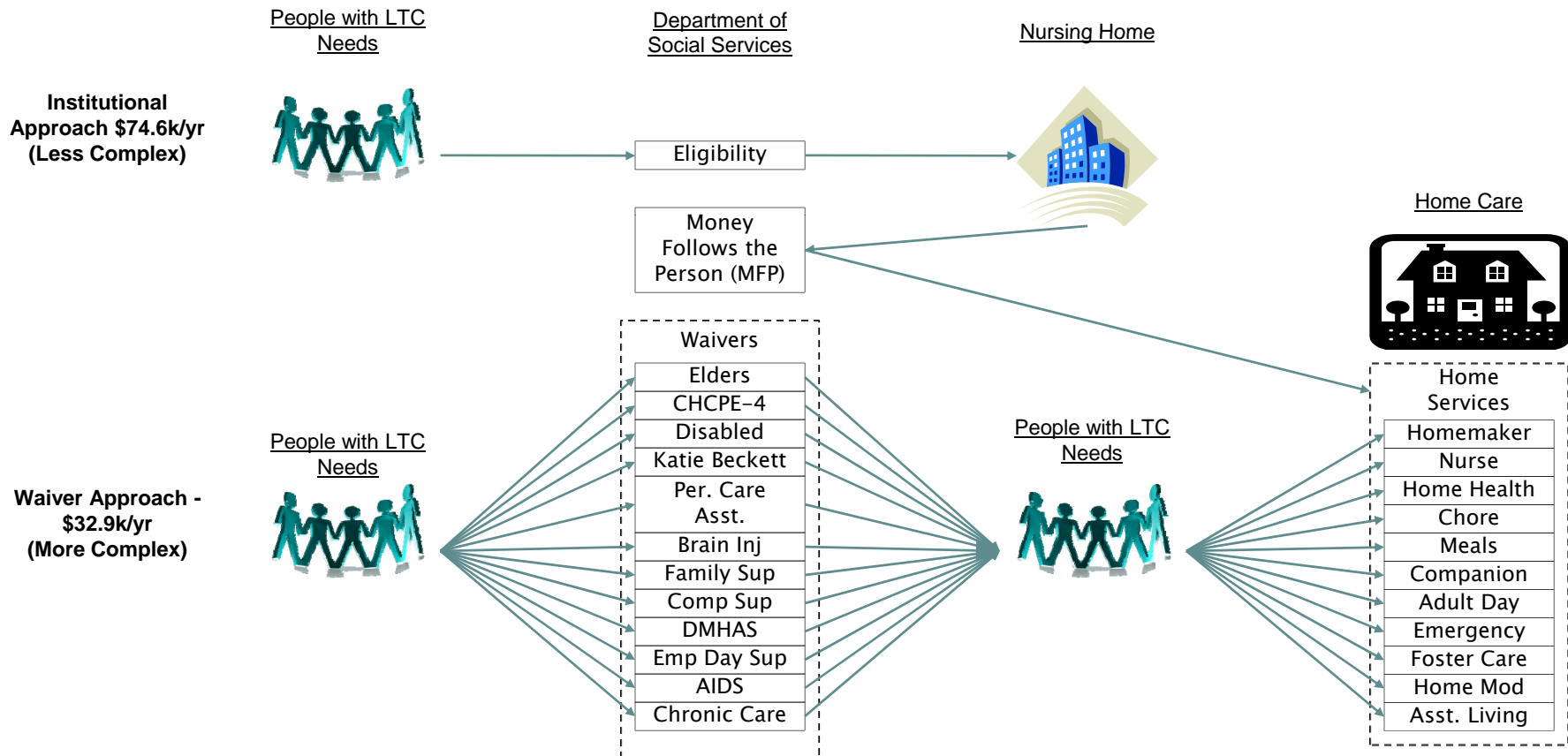
Rebalancing is Difficult – Waiver System



Source: Connecticut Commission on Aging, *Break Down the Silos – Streamline the Home & Community Based System*, December 9, 2009.

Rebalancing is Difficult

– Multiple Points of Entry



Note: This is a very simplified depiction of a very complex processes. This picture is not intended to cover every way to obtain long-term care.

Connecticut's Long-term Care Philosophy

- ▶ In 2005, a broad philosophical statement was enacted in Connecticut statute to guide policy and budget decisions. It states *that Connecticut's long-term care plan and policy must provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting.* This simple statement, designed to make real choices for individuals a reality, provides a larger framework for Connecticut upon which the Plan goals, recommendations and action steps rest.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 12.

- ▶ This statute was passed on October 5, 2005 in response to the Olmstead decision handed down by the U.S. Supreme Court in 1999.

Source: Connecticut House Bill #6786 ,Year 2005, File No. 105

Connecticut Initiatives

Money Follows the Person (MFP)

- ▶ MFP is a recent 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.

- ▶ 176 persons transitioned from 84 different nursing homes
 - Quality of life data has been collected and is being analyzed
 - Cost comparisons between MFP and institutional care has been analyzed

Source: Connecticut Department of Social Services, *Money Follows the Person Rebalancing Demonstration Legislative Status Update*, January 29, 2010.

Connecticut Initiatives

Money Follows the Person (MFP)

- ▶ The actual cost of care for persons in the MFP program is less expensive than institutional care.

Actual Program Cost Comparison per Client

Institutional Care		Money Follows the Person	
Monthly Program Cost	\$6,658	Monthly Program Cost • MFP Services \$3,388 • Rental Assistance \$288	\$3,676
Federal Match	\$4,008	Federal Match	\$2,713
Net Cost to State	\$2,651	Net Cost to State	\$963

Source: Connecticut Department of Social Services, *Money Follows the Person Rebalancing Demonstration Legislative Status Update*, October 2009.

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.

Connecticut Initiatives

- ▶ Long-term care services and support website
- ▶ Home and Community Based Services Programs (Waivers)
- ▶ Mental Health Transformation Grant
- ▶ Aging and Disability Resource Centers (ADRCs)
- ▶ Nursing Facilities (small house)
- ▶ Connecticut Department of Aging
- ▶ Federal Stimulus Funds

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 7-11.

Recommendations

- ▶ Provide Strong Leadership
 - The Governor and Legislature must make the Connecticut Long-Term Care System a priority.
 - Rationale for Change:
 - Long-term care affects everyone
 - The system is expensive and will get worse
 - Connecticut is behind other states
 - Potential Implementation Approaches:
 - Appoint a cabinet level position to lead and manage long-term care
 - Create and support legislation that does not allow short-term budget pressures to interrupt investments in the long-term care system
 - Strengthen OPM's role as a point of coordination for long-term care.
 - Aggressive pursuit of federal funding

Recommendations

- ▶ Create a Strategy and Align the Long-Term Care System
 - Under the governor's and legislature's leadership, a long-term care strategy must be developed. The implementation of this strategy must align all aspects of the long-term care system with the existing statute.

“individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting”
 - Rationale for Change:
 - The existing system was created prior to the emergence of HCBS and has a bias towards institutions
 - HCBS capacity must grow to support increasing demand for long-term care
 - HCBS and Institutional Care are both important elements of the continuum of care for LTC.
 - The strategy must ensure the health and viability of HCBS and Institutional Care providers.
 - The Connecticut Long-Term Care Plan has good ideas that are a guide but there is no accountability for implementation
 - Key Elements that should be addressed in a Connecticut Long-Term Care Strategy are:
 - Organization Structure
 - Clearly Defined Goals
 - Process and Technology
 - Measurement and Accountability

Recommendations

- ▶ Consolidate and Integrate State Long-Term Care Functions
 - Establish a consolidated, efficient all-ages human services approach to long-term care in Connecticut that maximizes the impact of Medicaid dollars and Older Americans act funds rather than dividing them up.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, Part II, pp 72.

- Rationale for Change:
 - Connecticut has a fractured governance structure for providing administrative and programmatic support to older adults and person with disabilities. A number of different state departments and agencies are responsible for services and funding for different populations and programs. There are four major agencies responsible for various aspects of long-term care in Connecticut: the Department of Social Services, Mental Retardation* (including the Ombudsman programs associated with those two agencies), Mental Health and Addiction Services and Public Health. There are many more that play lesser but still significant roles. This organizational complexity poses significant challenges for both consumers and providers of long-term care services. Further uncertainty has been created by a legislative mandate to create new Department on Aging.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, Part II, pp 8.

* Now named Department of Developmental Services

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Recommendations

- ▶ Simplify Connecticut's Medicaid Structure
 - Eligibility for long-term care services and supports should address functional needs and not exclude individuals due to age or particular disability. Policy and program changes should create parity among age groups, across disabilities, and among programs through allocating funds equitably among people based on their level of need rather than on their age or type of disability.
 - Rationale for Change:
 - The Medicaid program is particularly complex, especially with regard to the separate long-term care pilot programs and home and community-based waivers that vary in terms of eligibility, services provided and types of disabilities that are addressed.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 58.

Recommendations

- ▶ Create a statewide single-point of entry (SPE) or No Wrong Door (NWD) long-term care information and referral program across all ages and disabilities.
 - An expert team comprised, for example, of State Unit on Aging staff, members for the Long-Term Care Planning Committee and Advisory Council, consumers and providers should develop a plan to implement a centralized SPE/NWD in Connecticut. The SPE/NWD should encourage equity in allocation of services and support across ages and across disabilities. Many of the 43 jurisdictions throughout the U.S. with existing Aging and Disability Resource Centers (ADRCs) present models for doing so. The SPE/NWD should also inform the hospital discharge planning process to avoid unnecessary institutionalization, and should consider the creation of common applications for program eligibility to avoid the necessity of giving the same information multiple times.
 - Rationale for Change:
 - Survey respondents, providers and state agencies all reported that it is difficult for Connecticut residents who need long-term care to find basic information about the types of care that are available to them and who will provide this care.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, Part I, pp 32.

Goals

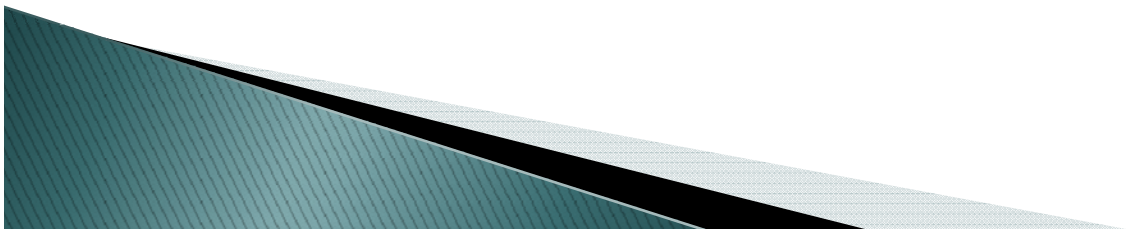
- ▶ Balance the Ratio of Home and Community-Based and Institutional Care
 - Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional setting, and increases the proportion of individuals receiving Medicaid home and community-based care from 53 percent in 2009 to 75 percent by 2025, requiring approximately a one percent increase in the proportion of individuals receiving Medicaid long-term care in the community every year.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 53.

Goals

- ▶ Balance the Ratio of Public and Private Resources
 - Increase the proportion of long-term care costs covered by private insurance and other dedicated sources of private funds to 25% by 2025. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 55.



Recommendations

- ▶ Other specific recommendations that should be considered can be found in:
 - Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 57-78.
 - University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 32-35.

Other States - Washington

- ▶ Washington has one of the nation's most balanced LTC systems for older people and adults with physical disabilities. It is one of the few states that spend more on HCBS than on nursing homes—in 2006, 54 percent of Medicaid LTC dollars were allocated to HCBS. From FY 2001 to FY 2006, Medicaid spending on HCBS increased significantly from \$439 billion to \$642 million, while spending on nursing homes decreased from \$614 million to \$558 million. Faster, more efficient access to HCBS is available through the following:
 - Single state agency administering and funding for institutional and HCBS;
 - Presumptive Medicaid financial eligibility process that allows a caseworker to approve and begin services while detailed paperwork proceeds;
 - Expedited eligibility determination process; and
 - Computerized assessment tool used to determine functional eligibility and development of care plans.

Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

- Washington State Department of Social and Health Services, *Fact Sheet – A Successful Vision*, December 2009 <http://www.aasa.dshs.wa.gov/about/factsheets/default.asp>

Other States - Oregon

- ▶ Oregon has the nation's most balanced LTC system for older people and adults with physical disabilities, and recent trends indicate that the state is continuing to make even more progress toward balancing. About three times as many Medicaid participants receive HCBS increased from 1999 to 2004, while the number of participants in nursing homes decreased by nearly 12 percent. From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS was more than twice the increase in spending for nursing homes. Oregon is one of the few states that spend more on HCBS than on nursing homes.
- ▶ Oregon was awarded one of the largest Money Follows the Person grants in May 2007 – 114.7 million over five years. In their proposal, state officials said they would use the grant to demonstrate that “long-term institutionalized populations of people with complex medical and LTC needs can be served in their communities with wrap-around packages of supports and services.” The 780 people whom the state will assist to move to the community account for 16.5 percent of Oregon's institutionalized Medicaid population. Of the total, 300 are older people with end-stage dementia.

Source: AARP Public Policy Institute, *A Balancing Act: State Long-Term Care Reform*, July 2008, Oregon.

Other States - Vermont

- ▶ Vermont illustrates a state that is balancing its LTC system by combining nursing home and HCBS funds into a “global budget” to fund a consumer’s entitlement to either nursing home or home and community care. The state implemented “Choices for Care” program in October 2005. Before program implementation, 2,286 people were in nursing homes, 1,207 were receiving home and community based services, and 207 were on a waiting list. As of December 2007, the number of nursing home residents had dropped to 2,070, while the number of people receiving HCBS had increased to 1,875. As of April 2008, 31 people were on a waiting list for services.
- ▶ In 1996, the Vermont legislature enacted Act 160, which required the state to shift dollars saved from reduced Medicaid nursing home utilization to HCBS. The original goal was to serve a minimum of 40 Medicaid home and community-based clients for each 60 Medicaid-funded nursing home residents per county. In 2008, the state set a new target of 50-50.13 When Act 160 was passed, 88 percent of Medicaid LTC dollars were allocated to nursing home care and 12 percent to HCBS. In 2008, the allocation is 62 percent for nursing homes and 38 percent for HCBS.

Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

Other States - Minnesota

- ▶ Minnesota – 2001 – Enacted Comprehensive Legislation (S.F. 4, 1st Special Session) to Rebalance the state's LTC system, building on the recommendations of a Long-Term Care Task Force. The results were:
 - Minnesota's nursing home utilization rate was one of the nation's highest in the 1990s—84 beds per 1,000 people age 65 and older in 1993—despite a statewide moratorium on new nursing facility construction since 1984. Through a number of other initiatives such as a voluntary program under which the state provides facilities with financial incentives for closing beds, the ratio of beds to 1,000 people age 65 and older dropped to 56 in 2008. (This compares to a national average of 45 beds per 1,000 people age 65 and older in 2007.)
 - In 2001, Minnesota allocated about 82 percent of Medicaid LTC dollars for nursing home care. By 2006, that had dropped to about 60 percent.
 - Spending on home and community-based care more than doubled between FY 2001 and FY 2006, from \$209 million to \$566 million, while spending on nursing homes decreased from \$901 million to \$853 million.
 - The state now provides LTC consultation services to help consumers and their families choose LTC services that reflect their needs and preferences. Services are available locally from county teams of social workers and public health nurses.
 - Minnesota was one of 10 states to receive a \$500,000 grant in 2007 from the Centers for Medicare and Medicaid Services to use a new State Profile tool developed to access its LTC system and to explore the development of prototype LTC balancing indicators.

Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

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Other States – New Jersey

- ▶ New Jersey – 2006 – “Independence, Dignity, and Choice in Long-Term Care” Act.
 - Expansion of Aging and Disability Resource Centers (ADRCs) to ensure consumers are informed about appropriate LTC options
 - Development of a global budgeting process to expand HCBS by allowing maximum flexibility for consumer choice between nursing homes and home care options
 - Implementation of a fast-track eligibility process under which consumers can receive HCBS for up to 90 days while they are completing the full eligibility process for Medicaid coverage;
 - Creation of a web-based client tracking system that will allow care workers to more efficiently coordinate services and supports.
- ▶ New Jersey Results
 - Nearly 1,000 nursing home residents have made the transition to alternative LTC options in the community.
 - Three Medicaid waiver programs for HCBS are being consolidated to provide greater consistency of services for consumers and their caregivers.
 - Aging and Disability Resource Centers are being developed in five additional counties, and fast-track eligibility became operational statewide in 2008.
 - In 2007, the state received a \$30.3 million Money Follows the Person Rebalancing Demonstration grant.

Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

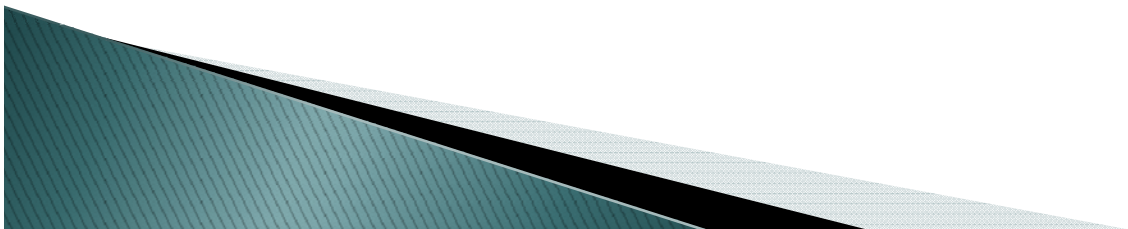
Other States – New Mexico

- ▶ New Mexico is implementing a coordinated, managed LTC program—“Coordination of Long-Term Services,” or “CoLTS”—for up to 38,000 Medicaid-eligible individuals, including those who have dual eligibility for Medicare and Medicaid, those who need a nursing facility level of care, and those who participate in the state’s disabled and elderly waiver program or receive services under the Medicaid State Plan personal care option.
- ▶ CoLTS began July 1, 2008, in selected counties and will provide primary, acute, and LTC services in one integrated program. CoLTS provides an example of a state teaming up with Medicare health plans to develop a coordinated system.

Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

Appendixes

- ▶ Long-Term Care Stakeholders
- ▶ Research Literature



Long-Term Care Stakeholders

Connecticut Long-Term Care Planning Committee

Legislators

- ▶ Senator Edith G. Prague, Co-Chair, Select Committee on Aging
- ▶ Representative Joseph C. Serra, Co-Chair, Select Committee on Aging
- ▶ Senator John A. Kissel, Ranking Member, Select Committee on Aging
- ▶ Representative John H. Frey, Ranking Member, Select Committee on Aging
- ▶ Senator Jonathan A. Harris, Co-Chair, Public Health Committee
- ▶ Representative Elizabeth B. Ritter, Co-Chair, Public Health Committee
- ▶ Senator Dan Debicella, Ranking Member, Public Health Committee
- ▶ Representative Janice R. Giegler, Ranking Member, Public Health Committee
- ▶ Senator Paul R. Doyle, Co-Chair, Human Services Committee
- ▶ Representative Toni E. Walker, Co-Chair, Human Services Committee
- ▶ Senator Robert J. Kane, Ranking Member, Human Services Committee
- ▶ Representative Lile R. Gibbons, Ranking Member, Human Services Committee

State Agencies Representatives

- ▶ David Guttchen, Office of Policy and Management (Chair of Planning Committee)
- ▶ Kathy Bruni, Department of Social Services
- ▶ Deborah Duval, Department of Developmental Services
- ▶ Pam Giannini, Department of Social Services
- ▶ Jennifer Glick, Department of Mental Health and Addiction Services
- ▶ Dennis King, Department of Transportation
- ▶ Beth Leslie, Office of Protection and Advocacy for Persons with Disabilities
- ▶ Fran Messina, Department of Economic and Community Development
- ▶ Amy Porter, Department of Social Services
- ▶ Kim Samaroo-Rodriguez, Department of Children and Families
- ▶ Michael Sanders, Department of Transportation
- ▶ Janet Williams, Department of Public Health

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, Appendix B

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Long-Term Care Stakeholders

Long-Term Care Advisory Council

- ▶ Legislative Member Representative - Peter F. Villano (Co-Chair)
- ▶ CT Commission on Aging - Julia Evans Starr (Co-Chair)
- ▶ CT Association of Residential Care Homes - Sonja Zandri
- ▶ Personal Care Attendant - Debbie Legault
- ▶ CT Association of Area Agencies on Aging - Kate McEvoy
- ▶ CT Council for Persons with Disabilities - Mildred Blotney
- ▶ CT Association of Health Care Facilities - Richard Brown
- ▶ CT Assisted Living Association - Christopher Carter
- ▶ CT Association of Adult Day Care - Maureen Dolan
- ▶ Bargaining Unit for Health Care Employees/ 1199 AFL-CIO - Deborah Chernoff
- ▶ CT Family Support Council - Laura Knapp
- ▶ Consumer - Michelle Duprey
- ▶ AARP – CT - Brenda Kelley
- ▶ CT Association of Home Care, Inc. - Brian Ellsworth
- ▶ LTC Ombudsman's Office - Nancy Shaffer
- ▶ Legal Assistance Resource Center - Joelen Gates
- ▶ CT Community Care, Inc. - Molly Rees Gavin
- ▶ CT Hospital Association - Jennifer Jackson
- ▶ CRT/CT Assoc. of Community Action Agencies - Rolando Martinez
- ▶ CT Alzheimer's Association - Christianne Kovel
- ▶ CANPFA - Margaret Morelli
- ▶ Family Caregiver - Susan Raimondo
- ▶ CT Coalition of Presidents of Resident Councils - Veronica Martin
- ▶ American College of Health Care Administrators - George Giblin
- ▶ Consumer - Sue Pedersen
- ▶ Consumer – Vacant
- ▶ Non-Union Home Health Aid - Vacant

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, Appendix C

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