An Updated Assessment of Connecticut's Long-Term Services and Supports System

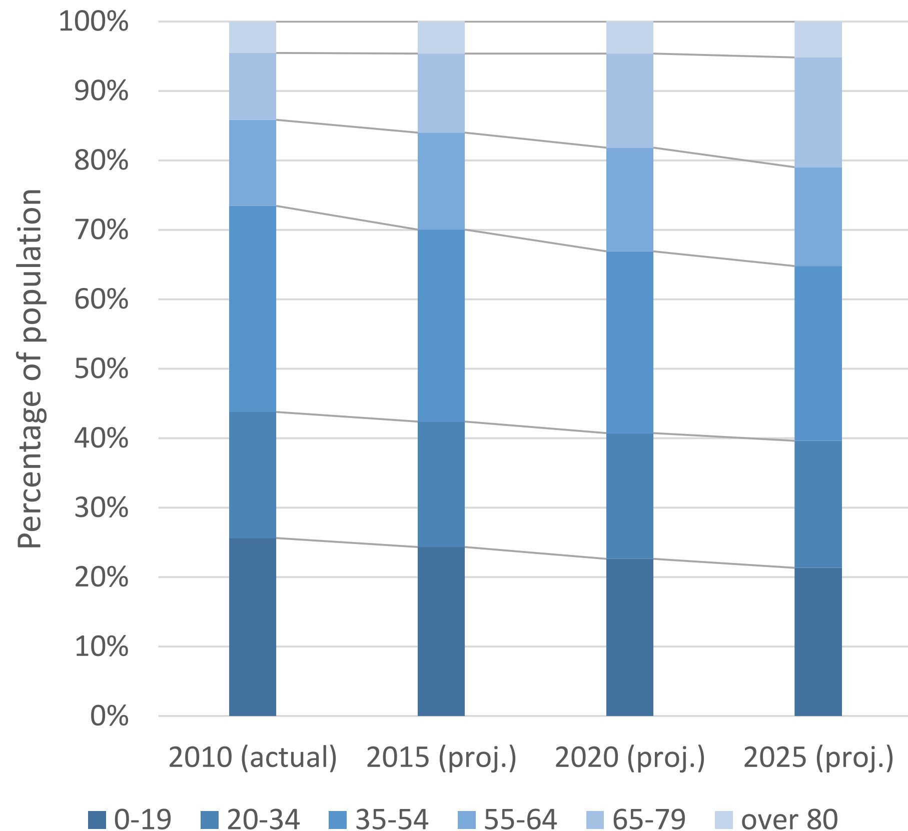
February 17, 2016

Overview

- Aging Baby Boomers will increase demand for long-term services and supports (LTSS), which could severely impact the state's fiscal situation
- Percentage of clients receiving LTSS in Connecticut in their homes and communities increased from 53% to 60% relative to those utilizing institutional care since 2009
  - The state's desired ratio of those utilizing home- and community-based care (HCBS) versus institutional care (75% and 25%, respectively)
  - Serving 75% of clients in a home or community setting could produce savings of $657 million in 2025 compared to the current service ratio
  - The state has increased the number and variety of programs providing LTSS and has taken advantage of several federal funding sources
- State needs to continue current programs and initiate additional improvements to reach the optimal percentage of services delivered through HCBS, limiting the budgetary impact of the aging population

An Aging Population

- State population growth over next 25 years will primarily be among those ages 65+
- Almost 47,000 individuals will need LTSS in 2025, an increase of almost 10,000 people from 2013
- Individuals need an average of three years of assistance, and needs typically increase with age



Source: Mercer, "State of Connecticut Medicaid Long Term Care Demand Projections, August 12, 2014."

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Projected Monthly Cost of Care in CT

	2012	2027 (percent change)
Home care – Homemaker services	$3,623	$3,772 (4.1%)*
Home care – Home health aide	$4,004	$3,862 (-3.5%)*
Adult day health care	$1,733	$2,589 (49.4%)
Assisted living facility – Private one bedroom	$5,000	$10,865 (117.3%)
Nursing home – Semi-private room	$11,771	$20,067 (70.5%)
Nursing home – Private room	$12,638	$21,890 (73.2%)

- Costs for all types of LTSS care expected to increase significantly over next 15 years
  - Note that changes in costs of home care are likely understated, since estimates pre-date federal rule change on wages for home health care workers

Source: U.S. Department of Health and Human Services, Administration on Aging. "Costs of Care in Your State." Data sourced from: Genworth Cost of Care Study 2013.

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Potential Savings from Rebalancing

	HCBS*	Institutional care	Total
Current client ratio, 2015	60%	40%	
2025 expenditures with 2015 client ratio	$2.90 billion	$3.71 billion	$6.61 billion
Optimal rebalancing client ratio, 2025	75%	25%	
2025 expenditures with optimal client ratio	$3.64 billion	$2.31 billion	$5.95 billion
Annual savings in 2025 with optimal client ratio compared to 2015 client ratio			$657 million

- Increasing the proportion of LTSS clients served in HCBS to 75% would produce savings of $657 million in 2025 compared to costs at the current client ratio, assuming a constant number of recipients in 2025
- This would help limit the budget impact of the increased demand due to the aging population

*Source: CT Long-Term Care Planning Committee. "Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut. A Report to the General Assembly." January 2016. Data in table from: OPM analysis of data from DSS, American Community Survey, and Connecticut State Data Center. Expenditures include annual 5% compound rate increase. *Chart does not reflect any change in from federal rule change in 2015 concerning home care workers.*

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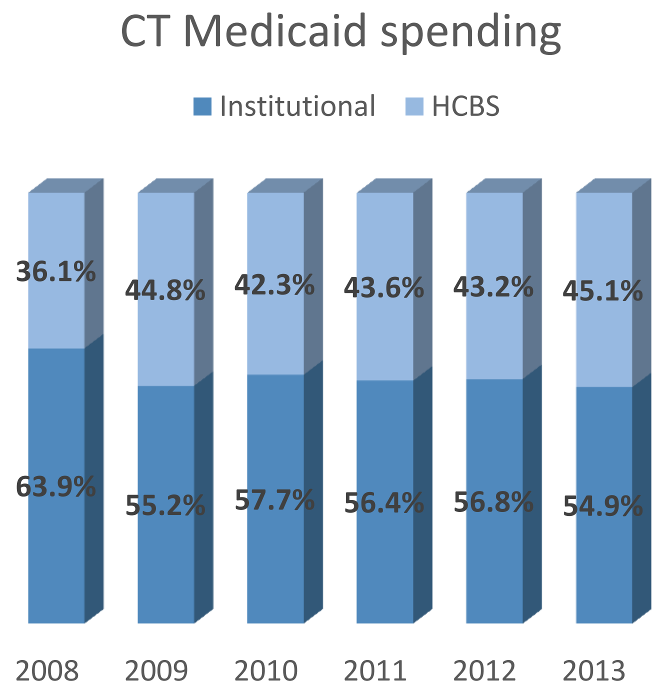
Update on Strategic Rebalancing Goals

These strategic goals were included in the previous CT21 report and are included in the Connecticut Long-Term Care Planning Committee's reports to the General Assembly.

Balance Ratio of Home and Community-Based and Institutional Care



Source: Truven Health Analytics. "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending." June 30, 2015.

- CT is increasing the percentage of LTSS spending in HCBS settings
- State rebalancing has slightly outpaced the U.S. although the state started with a higher percentage receiving institutional care

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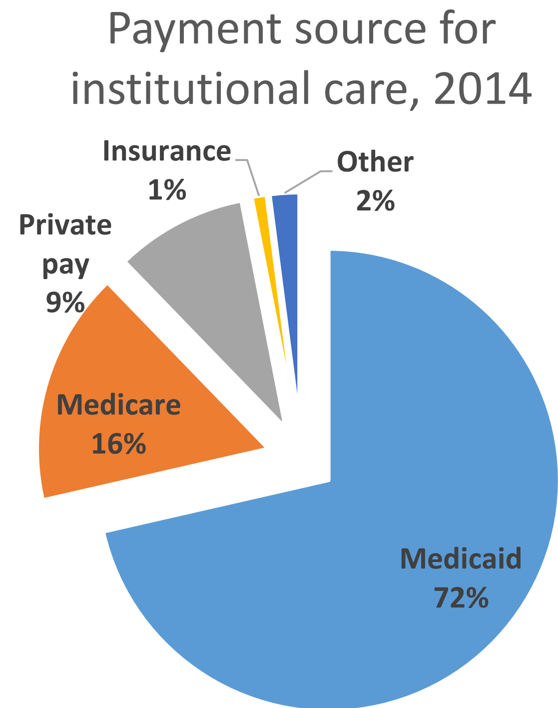
Balance Ratio of Public and Private Resources

- Most spending on LTSS in Connecticut continues to be from public funds, as is the case at the national level



Source: CT Long-Term Care Planning Committee. "Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut. A Report to the General Assembly." January 2016. Data in table sourced from: CT Nursing Facility Registry and Annual Nursing Facility Census, OPM.

Policy Changes

The state has increased the number and variety of programs providing LTSS, while both the federal and state governments have made other changes to LTSS systems.

Changing Playing Field of LTSS

- End of federal Money Follows the Person demonstration grants
- New state programs
- Unionization of home care workers in state
- Implementation of federal rule requiring home care agencies to pay minimum and overtime wages

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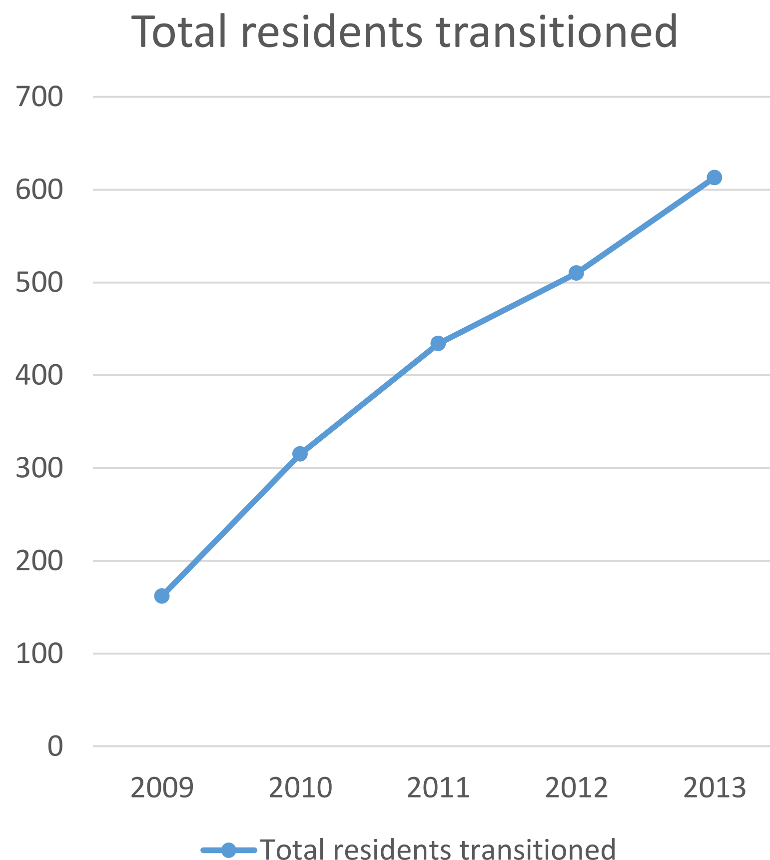
Money Follows the Person (MFP)

- Goal is rebalancing, or transitioning individuals from nursing facilities to home and community-based care
  - Nursing Facility Diversification/ Rightsizing Grants
  - Pilot program for presumptive eligibility
- Final round of federal funding in 2016
  - Funds can be used through 2020
  - Sustainability plan submitted to Centers for Medicare & Medicaid Services in 2015



Source: UConn Health, Center on Aging. "CT Money Follows the Person Quarterly Report: Quarter 3, 2015: July 1, 2015-September 30, 2015."

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Community First Choice

- Program launched July 1, 2015
- Part of Medicaid (included in Affordable Care Act)
  - No waiting list or cap on number of participants
- Program features
  - Must meet specific level of care
  - Client directs own budget and assistance staff
  - Client hires personal care assistants (PCAs) without state-imposed qualifications
  - Case managers function as advisors for clients, rather than directing services – reduces client dependence on state for planning

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Select Other Actions/Programs

- Nursing facility beds moratorium extended indefinitely in 2015
- Balancing Incentive Program
- Testing Experience and Functional Tools (TEFT) grant
- CT Partnership for Long-Term Care
- CT Department of Aging
- Aging in Place Initiative
- Livable Communities Initiative
- CT Home Care Program for Elders
- Aging and Disability Resource Centers

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Result of CT LTSS Programs

Medicaid LTSS	Percentage of clients (2009)	Percentage of clients (2015)
Community-based care	**53.1%**	**59.6%**
Institutional care	**46.9%**	**40.4%**

Source: 2009 data: CT Long-Term Care Planning Committee. "Long-Term Care Plan: A Report to the General Assembly." January 2010. 2015 data: CT Long-Term Care Planning Committee. "Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut. A Report to the General Assembly." January 2016.

- Number of Medicaid LTSS clients increased by 14.4% from 2009 to 2015
- Institutional care represented only 40% of recipients but over 55% of expenditures
- CT spending on Medicaid LTSS was 15% of total state expenditures and 40% of state Medicaid spending in FY 2015

Source: CT Long-Term Care Planning Committee. "Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut. A Report to the General Assembly." January 2016.

Policy Recommendations

These recommendations are based on the progress the state has made and the changing landscape at both the federal and state levels.

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Establish LTSS Coordinator

- One agency or individual in state government should be formally tasked with LTSS coordination
- **Rationale:**
    - Responsibilities for LTSS programming now spread across at least 10 state agencies
    - One point of responsibility would continue effort to break down program silos and align program details or planning efforts
    - This would likely result in savings for state as duplication and redundancies decreased

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Broaden Scope of LTSS Planning

- Ensure LTSS planning incorporates related policy domains.
- **Rationale:**
  - Housing, transportation, and other public services will need to be modified to accommodate the growing needs of an aging population.
  - This would allow that population to "age in place," or limit reliance on institutional care. It would also increase the potential for effective transitions from institutional care to HCBS.
  - State is already moving forward with this, but it should be an explicit part of state LTSS planning

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Develop Plan for Increasing Size of LTSS Workforce

- The state needs to develop a comprehensive plan that balances needs of service recipients, concerns of service providers and paid care giver needs to meet increasing needs for LTSS
- **Rationale:**
  - Projected demand for LTSS-related occupations will continue growing
  - Self-employed or contractor caregivers do not have access to workers compensation, unemployment insurance, Social Security, etc.
  - Wages tend to be lower for home care positions than for positions in institutional care
  - State strategic plan includes funds for creating additional positions and retraining institutional employees for HCBS but this will not meet the need for LTSS workforce
    - May include support for formalizing positions through incentives such as outlining career paths and increasing post-hire training options

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Expand LTSS-HCBS Awareness Campaign

- Implement a comprehensive awareness campaign to increase understanding and uptake of HCBS.
- **Rationale:**
  - LTSS recipients and their care givers need to fully understand options available – including new programs, such as Community First Choice – and to reduce the bias toward institutional care.
  - This could enhance or utilize MyPlaceCT.org, the state's single point of entry for LTSS.

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Continue Process of Restructuring Provider Reimbursement Rates

- The state has begun the process for restructuring Medicaid reimbursements to institutional LTSS providers. It should continue this process to reflect changing service patterns under MFP.
- **Rationale:**
  - Factors to consider for inclusion in restructured rates:
    - Acuity-based reimbursements
    - Geographic adjustment factors
  - Rate adjustments can be phased in to limit effect on providers and communities. Reimbursement rates could continue to incorporate some cost reimbursement.

Develop Single Source of Data

- Develop a single metric for LTSS need to allow for consistent collection of data and evaluation of programs
- **Rationale:**
  - Currently many sources of data on those potentially needing LTSS and no single definition of disability or LTSS need

The full report is available at www.ct21.org.

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