

CT Money Follows the Person Report

Quarter 3: July 1 - September 30, 2023

UConn Health, Center on Aging

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

MFP Benchmarks

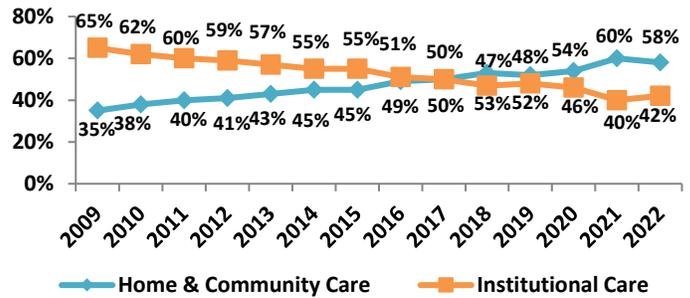
- 1) Transition 5200 people from qualified institutions to the community
- 2) Increase dollars to home and community based services
- 3) Increase hospital discharges to the community rather than to institutions
- 4) Increase probability of returning to the community during the six months following nursing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

Benchmark 1: Total Transitions = 7,798

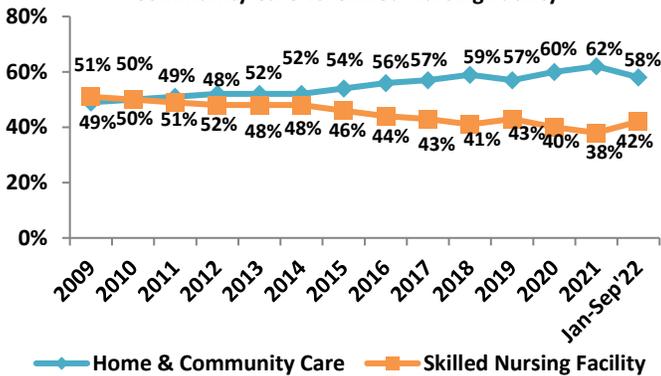
Demonstration = 7,308 (94%)

Non-demonstration = 490 (6%)

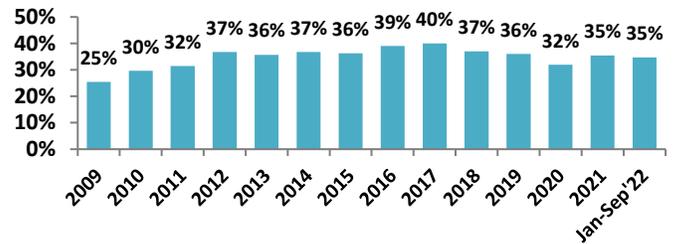
Benchmark 2 CT Medicaid Long-Term Care Expenditures



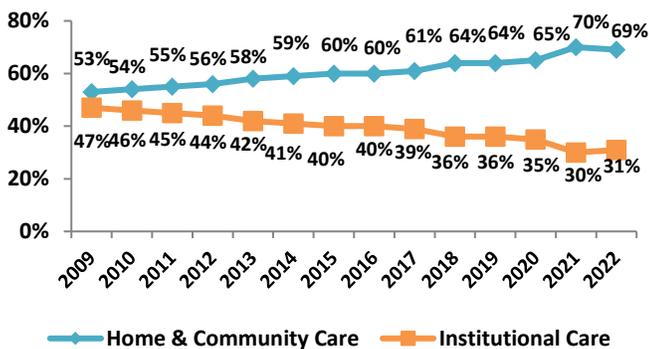
Benchmark 3 Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility



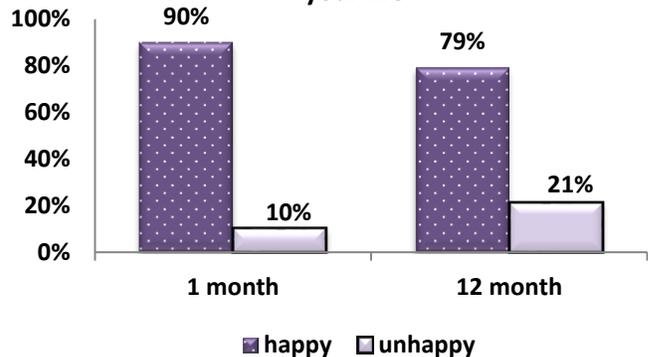
Benchmark 4 Percent of SNF admissions returning to the community within 6 months



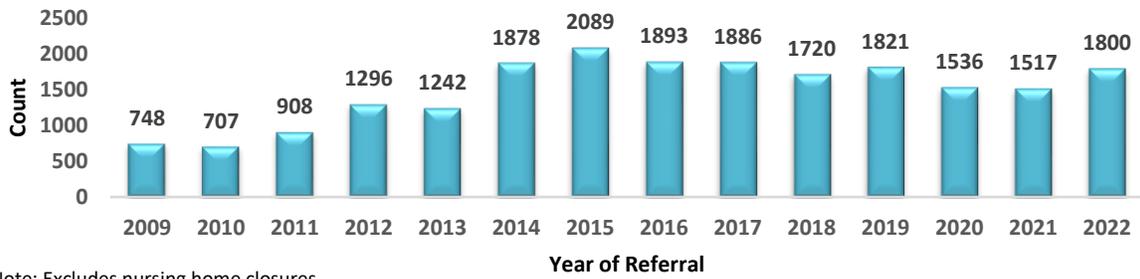
Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions



Happy or unhappy with the way you live your life

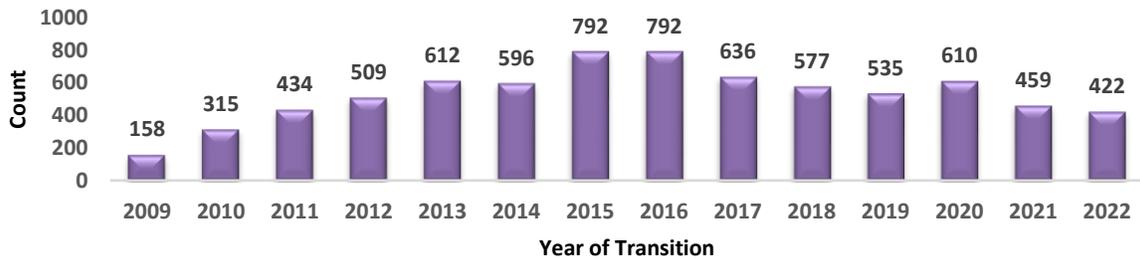


Total Number of Referrals Assigned to the Field by Year

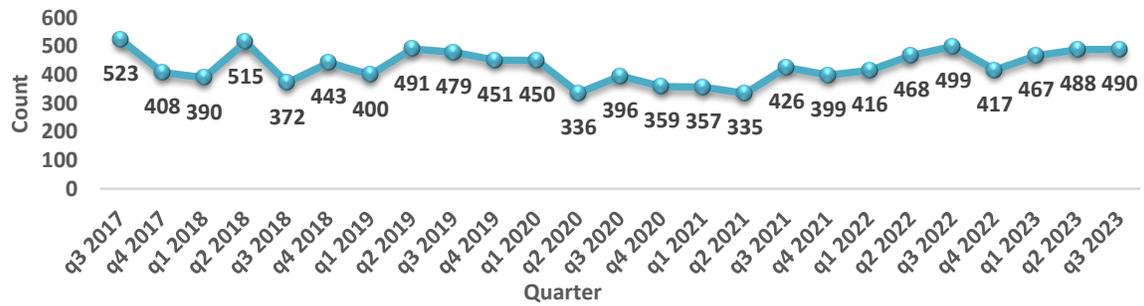


Note: Excludes nursing home closures

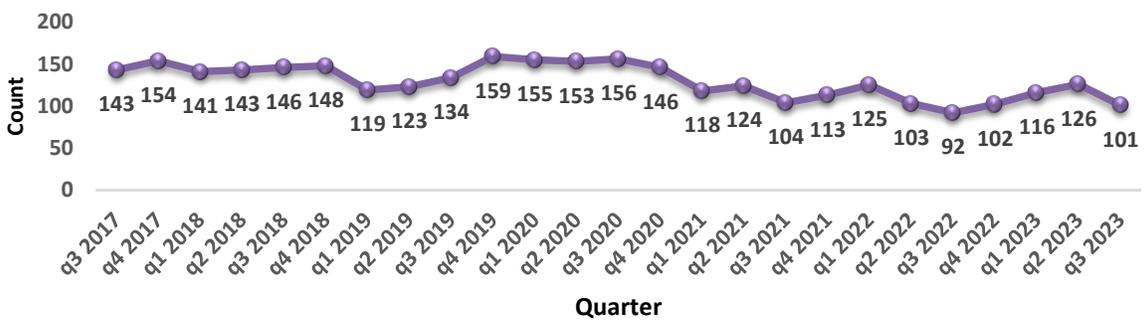
Total Number of Transitions by Year



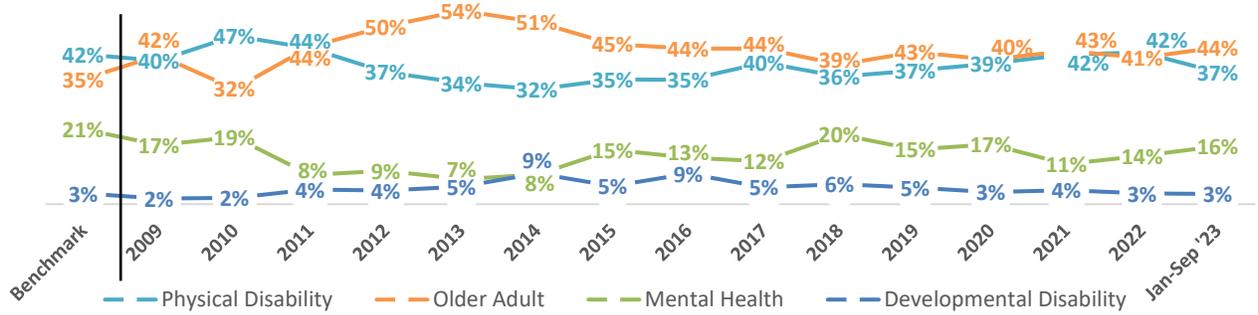
Referrals Assigned to the Field by Quarter



Number of Transitions by Quarter



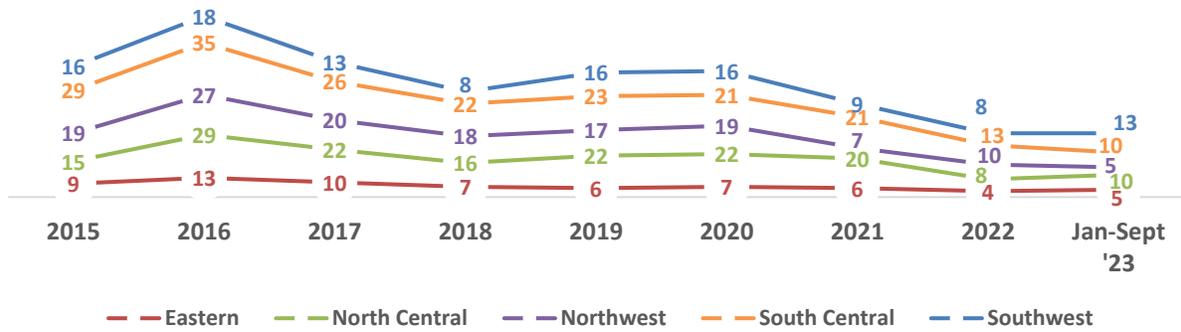
Target Population for Transitions by Year of Transition (Demonstration Only)



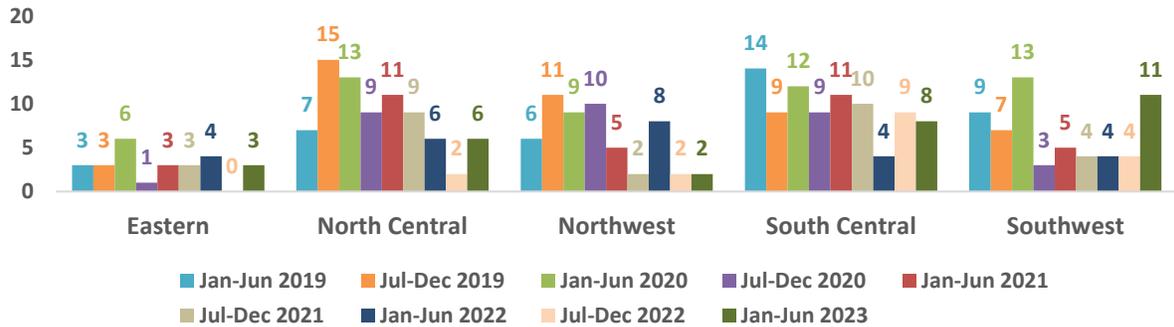
Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay



Number of Participants with Home Modifications by Year Approved and Region

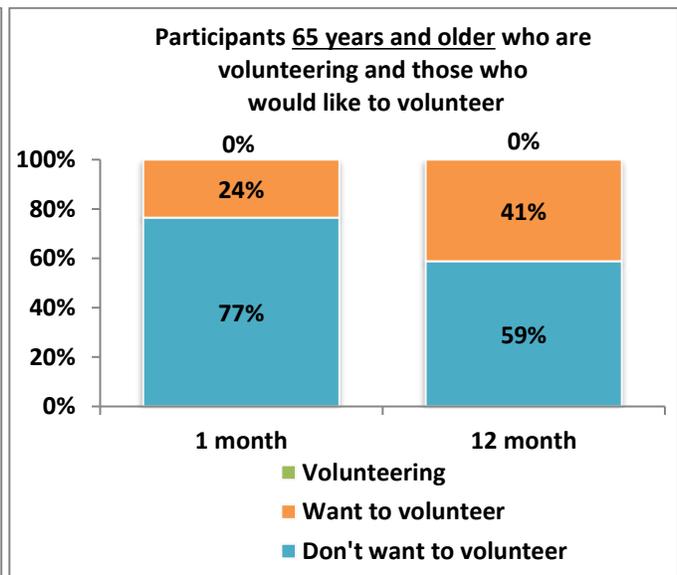
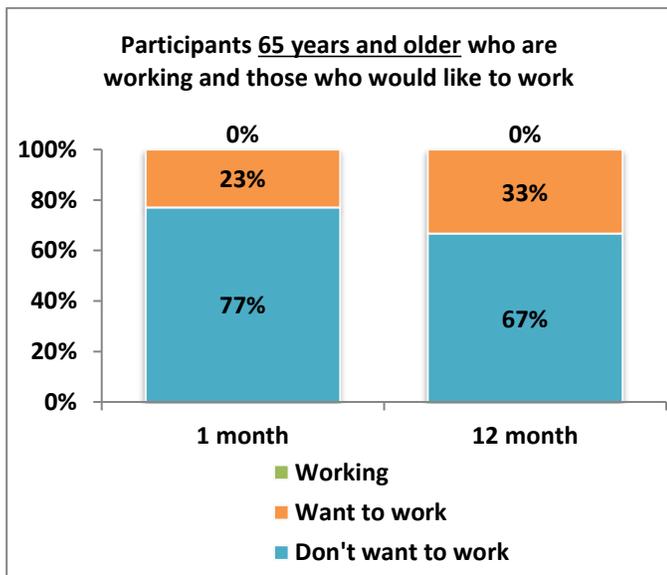
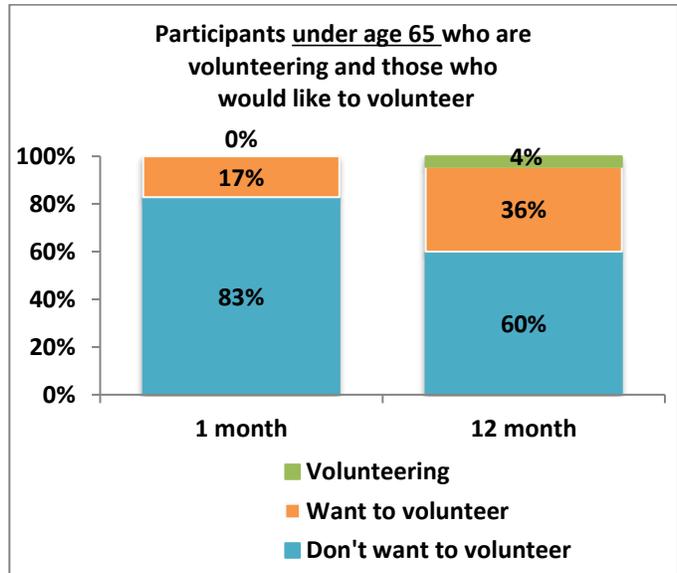
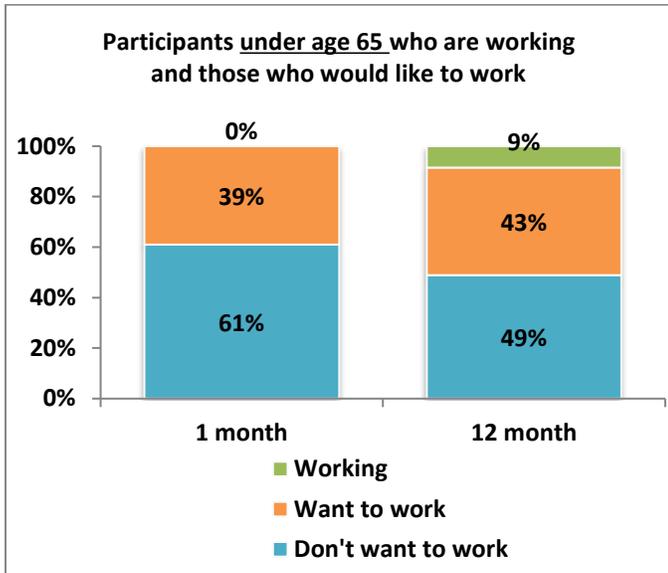


Number of Participants with Home Modifications per 6 Months



Participants who are Working and/or Volunteering (data 7/1/23-9/30/23)

Note: Data are participant responses to the HCBS CAHPS survey



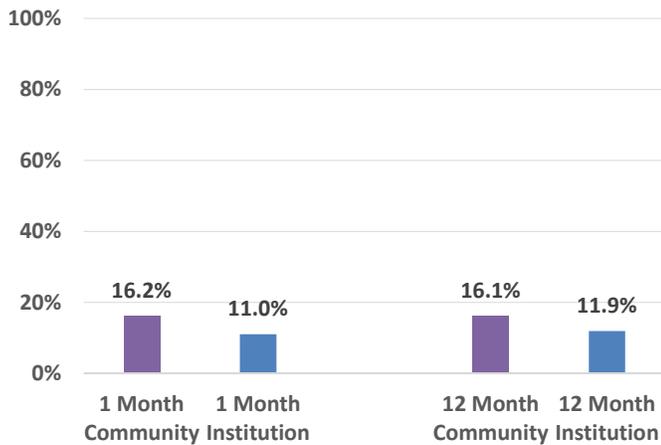
Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 9/30/2023



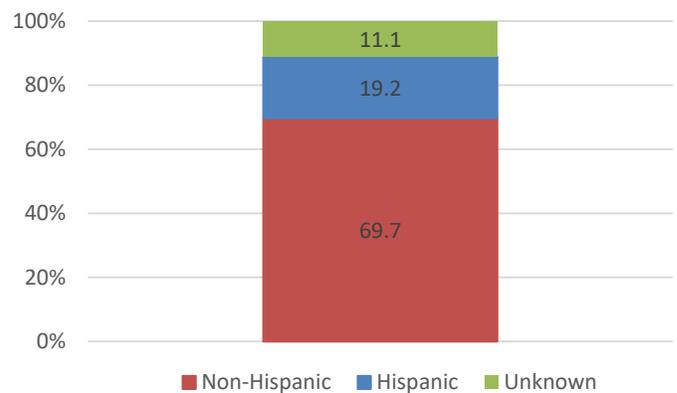
Race and Ethnicity for MFP Participants Transitioned 1/1/19 – 9/30/23 and for CT Medicaid Recipients in 2022

Note: MFP participant results are from responses to the HCBS CAHPS MFP Survey questions 87 and 89 at 1 and 12 month time points.

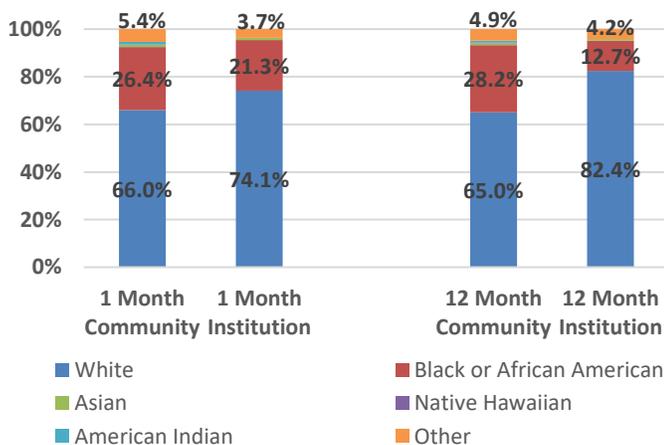
MFP Participants Who Are Hispanic



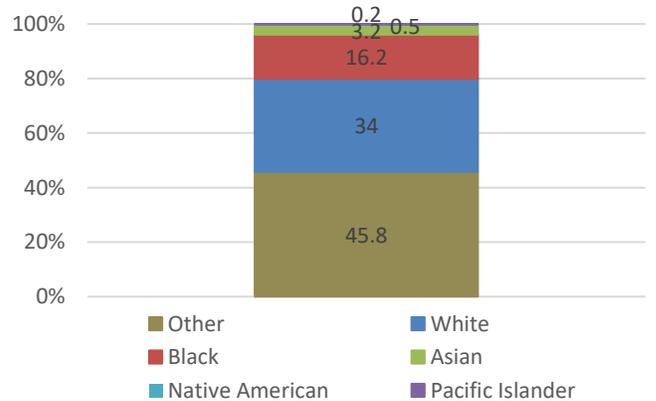
Reported Ethnicity for All CT Medicaid Recipients in 2022



MFP Participants' Self-Reported Race



Reported Race for All CT Medicaid Recipients in 2022

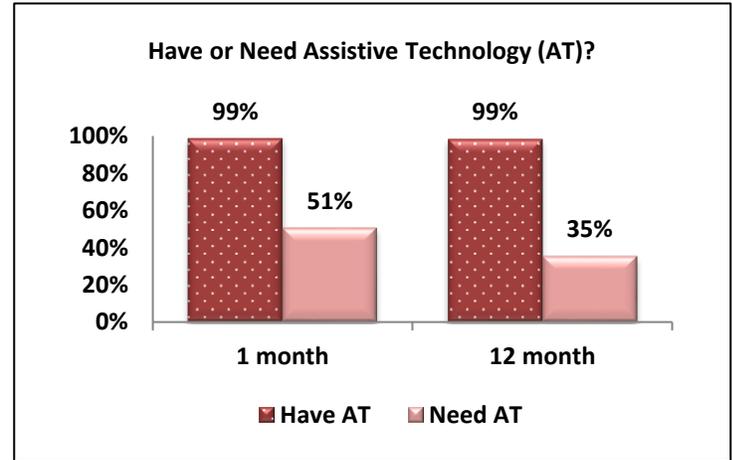
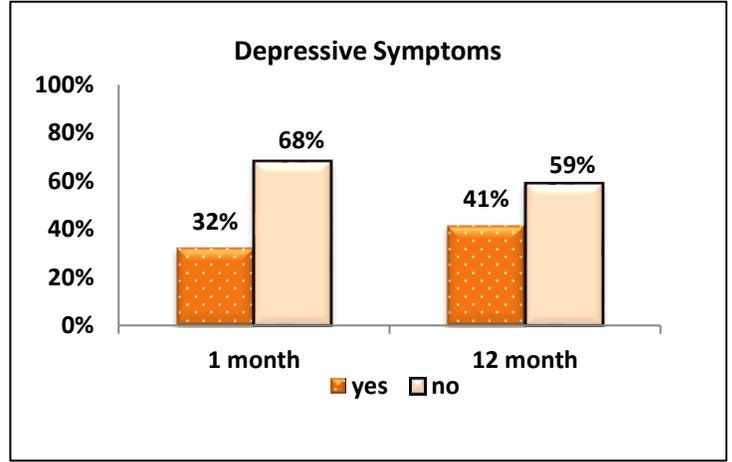
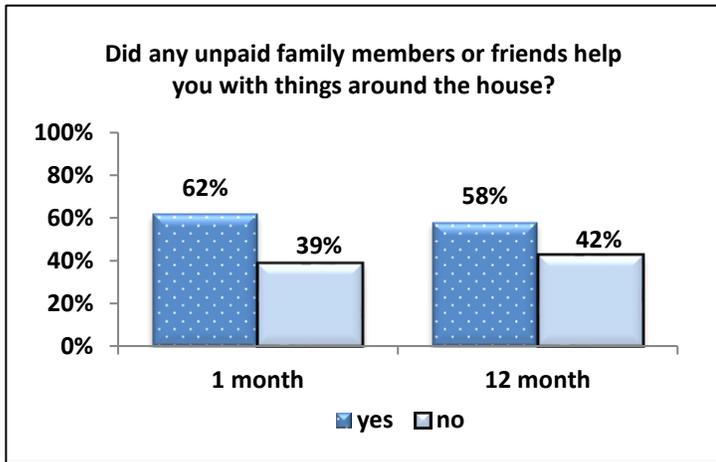
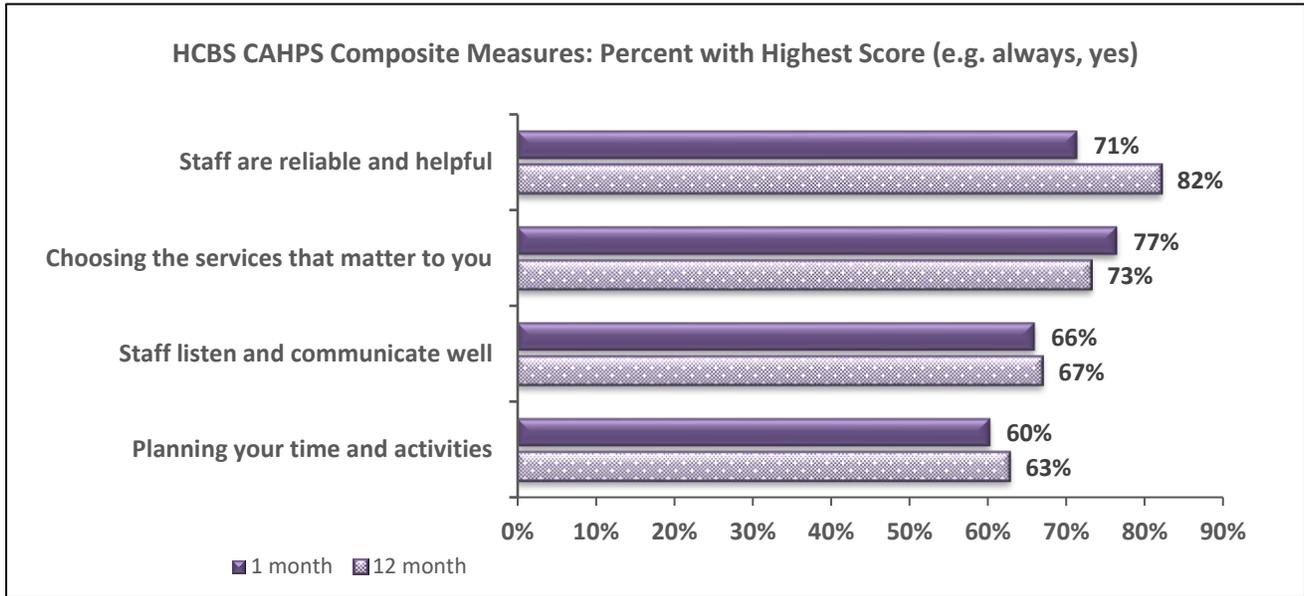


MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed from 7/1/2023-9/30/2023 (n=157)

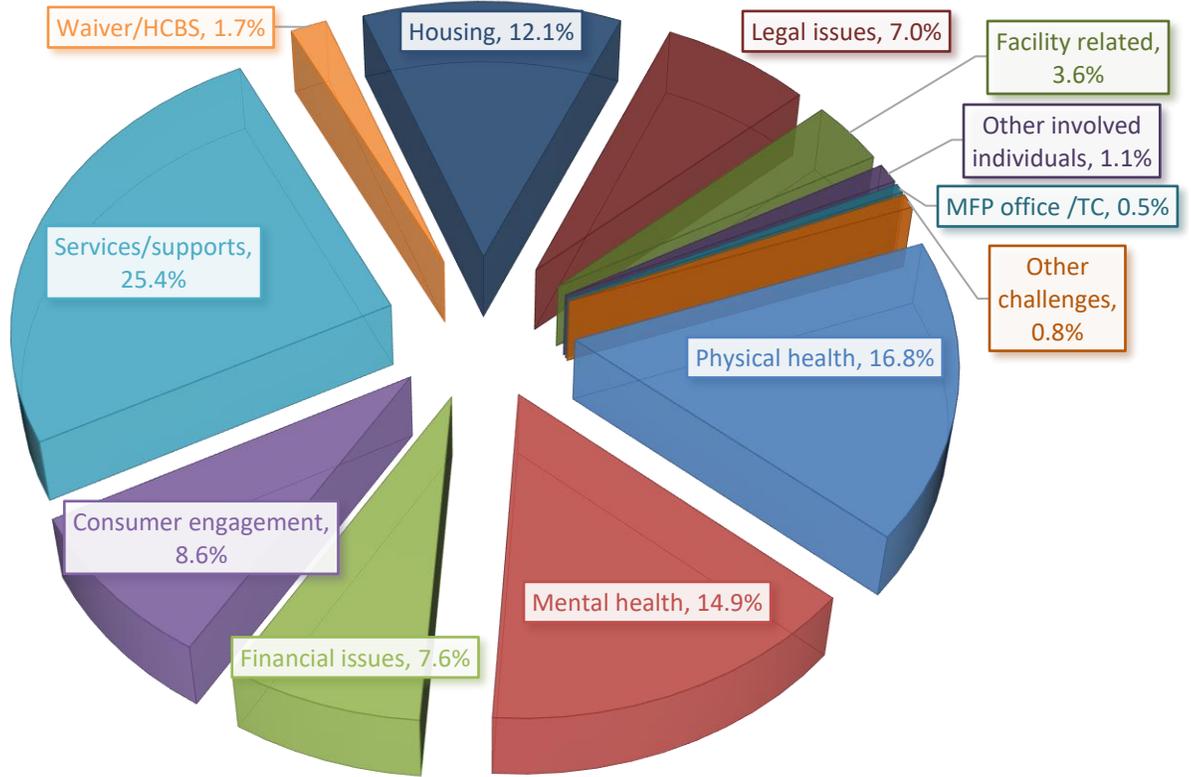
1 month interviews done 1 month after transition, n=80

12 month interviews done 12 months after transition, n=77

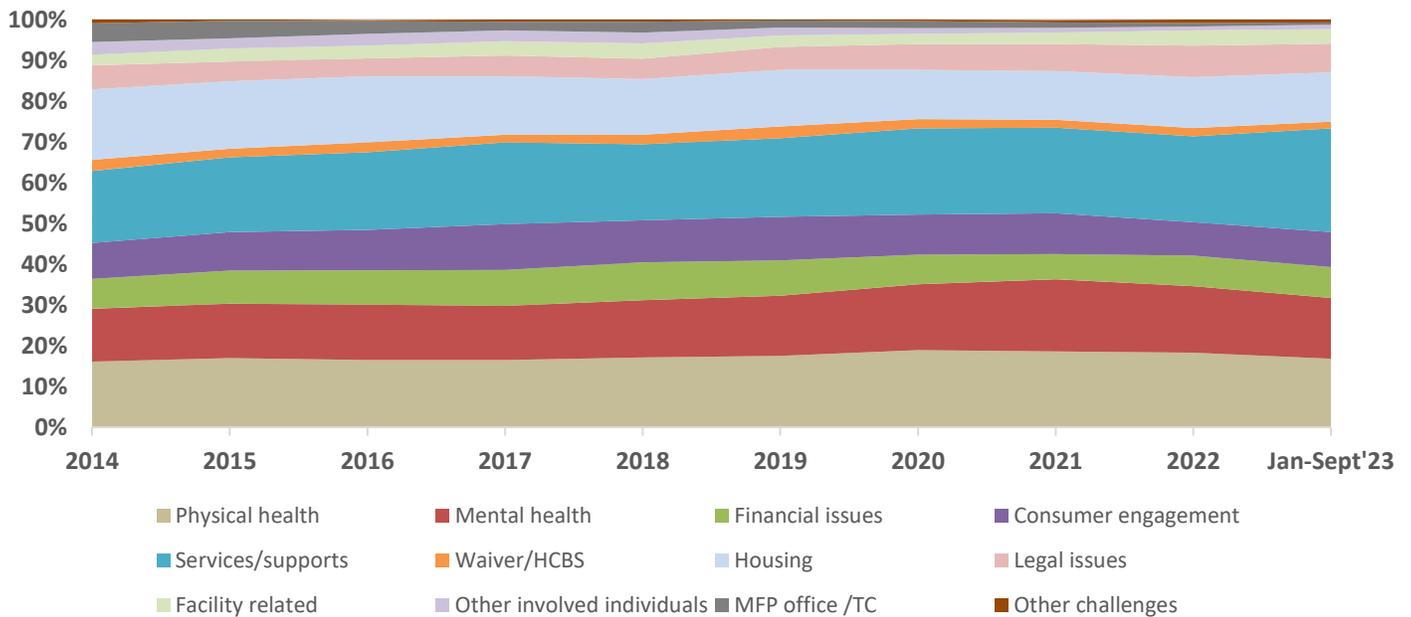


Challenges to Transition as Recorded by TCs and SCMs

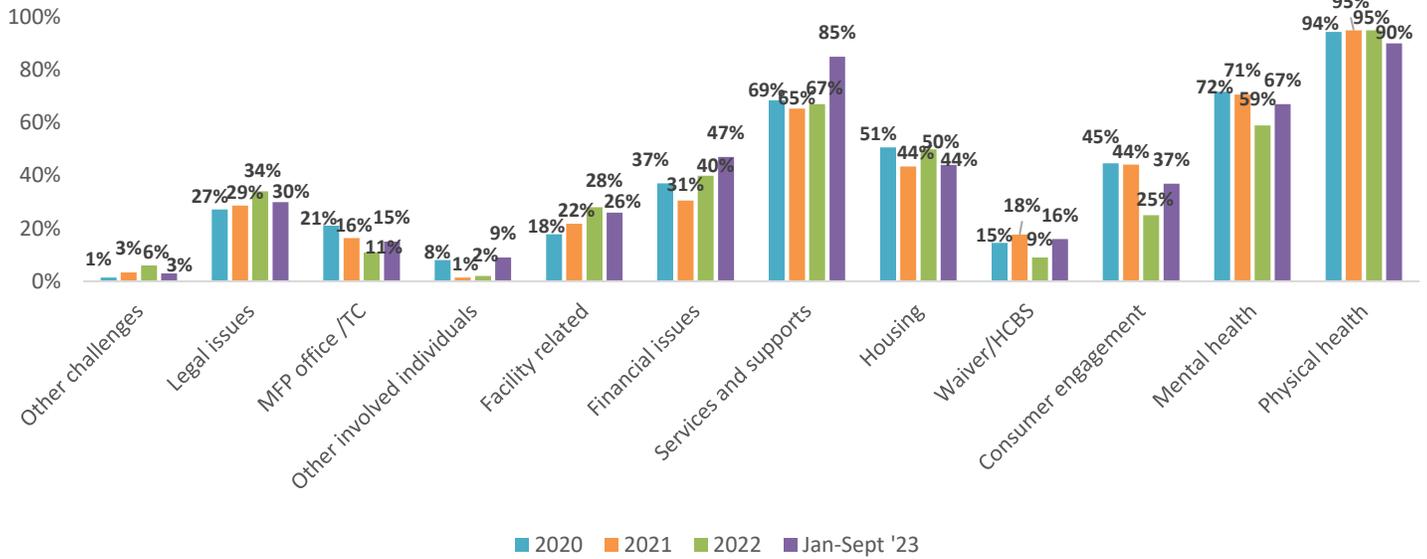
Transition Challenges for Participants Referred Jan-Sept 2023



Frequency of Transition Challenges by Year of Referral



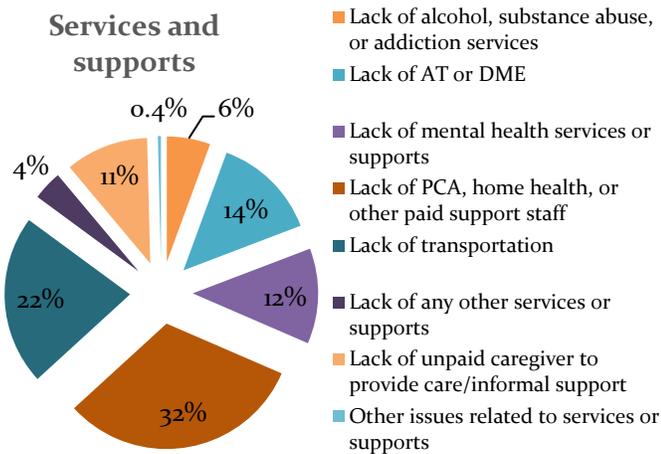
Participants with Each Challenge who Transitioned by Referral Year



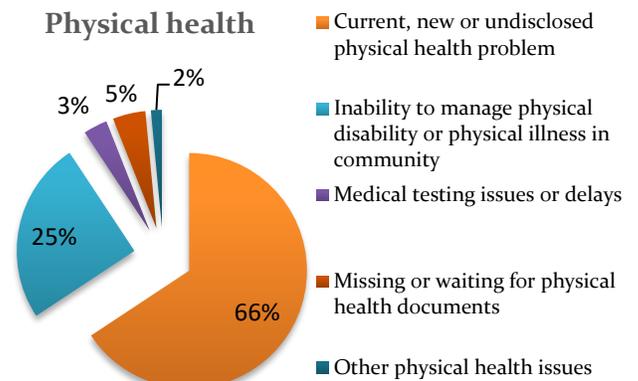
Types of Challenges for Referrals: 1/1/2023 - 09/30/2023

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

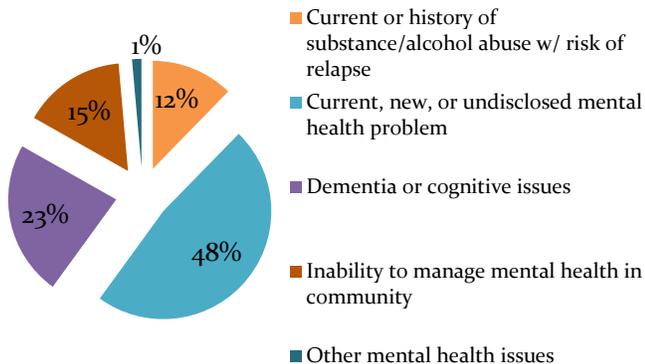
Services and supports



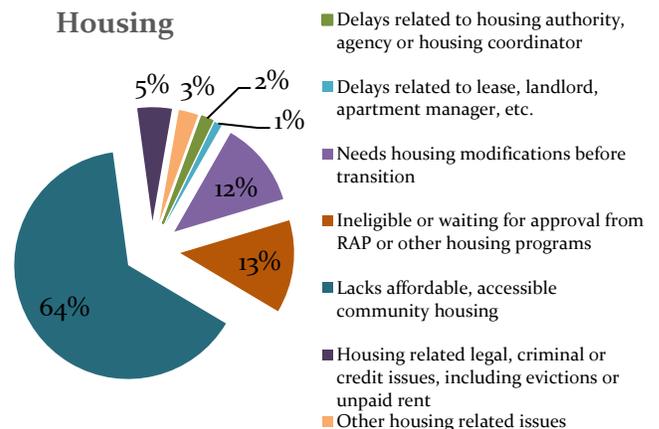
Physical health



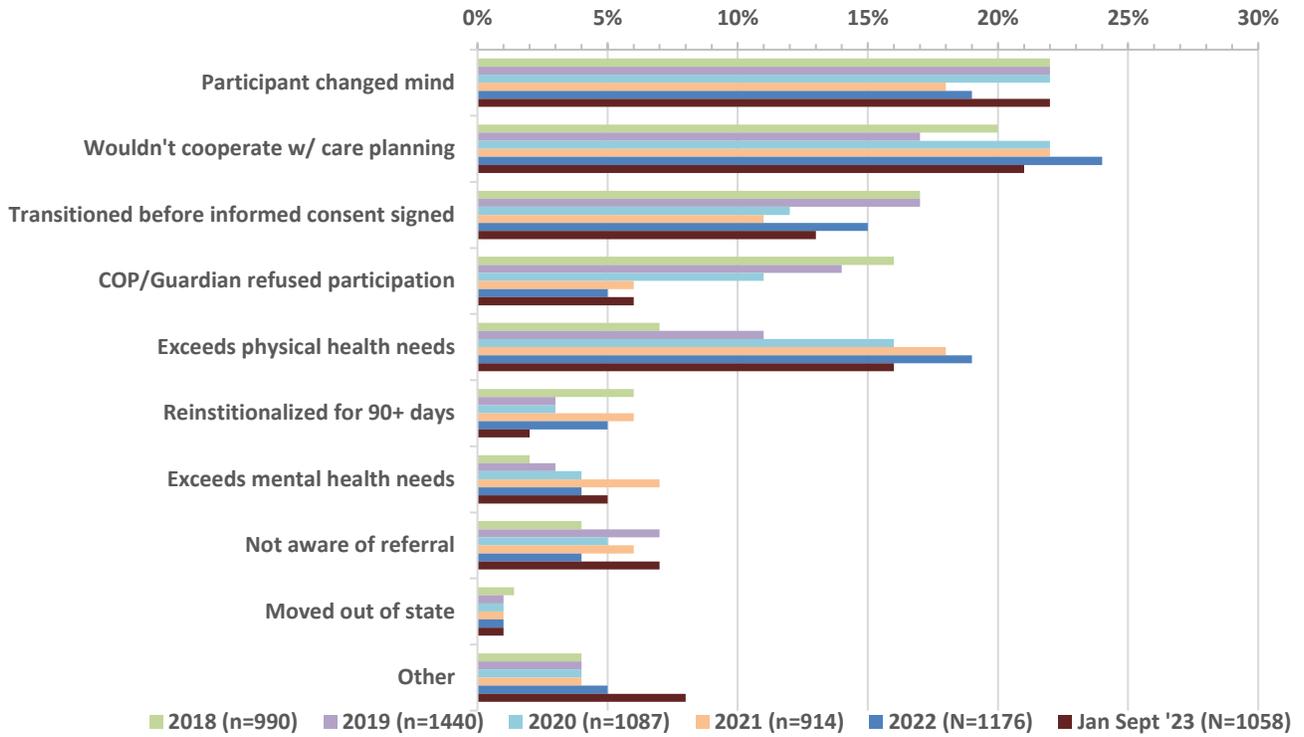
Mental health



Housing

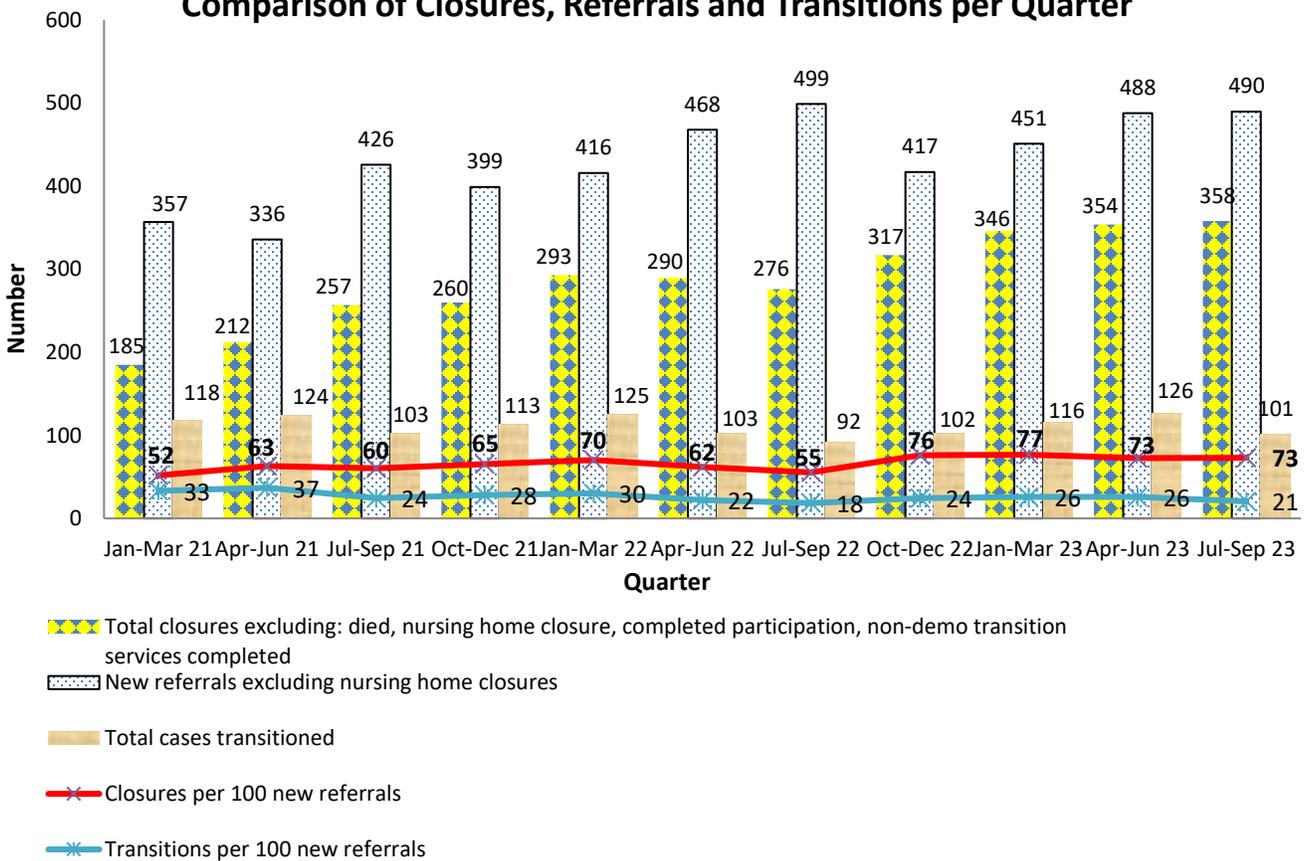


Frequency of Closure Reason by Year of Closure



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

Comparison of Closures, Referrals and Transitions per Quarter



Jennifer's Story

Jennifer has always been what most people would consider a “people person.” No matter where she goes, she can make a friend or strike up a conversation to pass the time. She loves to be in the company of others and loves to help others however she can. This made her a perfect fit for a job with Visiting Angels, a company providing home care for older adults. But in recent years, Jennifer has struggled with her health. After a stroke in 2019, she had her first short term nursing home stay and was unable to continue working upon returning home. She was also learning how to manage her newly diagnosed diabetes.

In 2021, Jennifer stubbed her toe. Due to complications from her diabetes, the wound on her toe refused to heal despite frequent medical examinations. To further complicate the situation, Jennifer contracted a mild case of Covid which she believes exacerbated her wound; 11 days after testing positive, the pain and swelling became unbearable and sent her to the ER for inconclusive tests. With some difficulty, her PCP got her a podiatry appointment. She arrived with a foot three times its normal size and in excruciating pain. Her foot and leg were also becoming numb, and she was starting to experience chest pain. Her doctor suspected a blood clot, and immediately called an ambulance to take her to the hospital for emergency surgery to remove the clot that was now threatening her life.

Jennifer was terrified after learning of her condition. Because of Covid, she could not have her family with her for support. She prayed heavily and relied on God to watch over her. After a successful surgery, she was alone in the hospital for about a week. Jennifer was happy to be recovering, but still very distressed about not seeing her family, even after being transferred to a nursing home for rehabilitation.

For a while, living at the nursing home was tough for Jennifer. She was the youngest person there and was often around older adults living with dementia. Because of Covid, she was mostly confined to her room and could not have visitors. She continued to pray and call on God to help lift her spirits. As her time there continued, true to her nature, she became very close with the facility staff and even some of the residents. She participated in all kinds of activities and helped other residents however she could. Jennifer explained, “That was my medicine.” She grew to love the community, both staff and residents.

She continued healing and working on her mobility while starting to think about next steps. The facility social worker introduced Jennifer to the Money Follows the Person program. She was a good candidate as she needed to find a place to live and have home care services in place once she moved. She met with a care manager and transition coordinator who were driven to help Jennifer reach her goals. Like many people on MFP, the hardest part was finding housing. Jennifer was lucky to have an abundance of family and friends who were willing to help. After 3 or 4 months of patience and prayers, Jennifer's niece found a brand new housing complex that was taking applications. Jennifer immediately submitted hers after seeing the beautiful, spacious units, many of which had a view of the nearby river. For Jennifer, her prayers continued working magic as her applications for the apartment and for rental assistance were accepted. On her transition day, Jennifer's family and transition coordinator eagerly helped set up her new place. With her transition budget through MFP, Jennifer's transition coordinator purchased necessities like food, small appliances and pots and pans. Her transition plan also included physical and occupational therapy, a personal care assistant, and a visiting nurse. Finally, all the pieces came together allowing Jennifer to live successfully on her own again.

Jennifer feels at home in her new apartment. This new chapter excites her, and she'll never stop thanking God, her family, and MFP for the opportunities. She's joined a new church down the street from her building. Even better, she's quickly made new friends there who've offered to provide a ride for her every Sunday. Jennifer explained, “God answered all my prayers and more.”



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.