

CT Money Follows the Person Report

Quarter 2: April 1 - June 30, 2024

UConn Health, Center on Aging

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

MFP Benchmarks

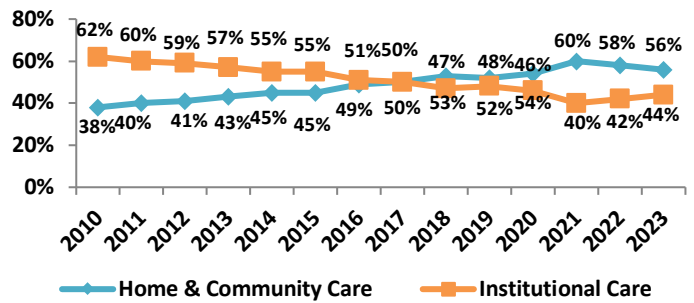
- 1) Transition 5200 people from qualified institutions to the community
- 2) Increase dollars to home and community based services
- 3) Increase hospital discharges to the community rather than to institutions
- 4) Increase probability of returning to the community during the six months following nursing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

Benchmark 1: Total Transitions = 8,147

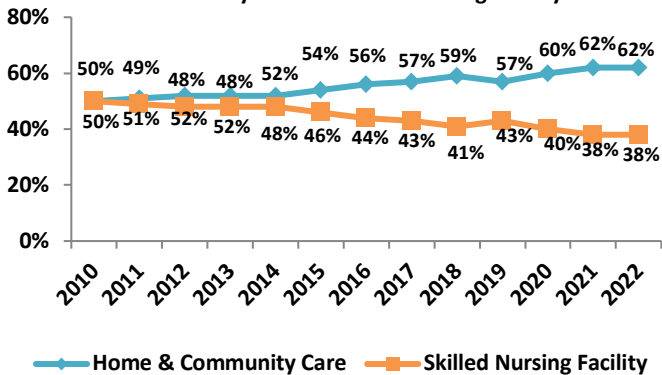
Demonstration = 7,625 (94%)

Non-demonstration = 522 (6%)

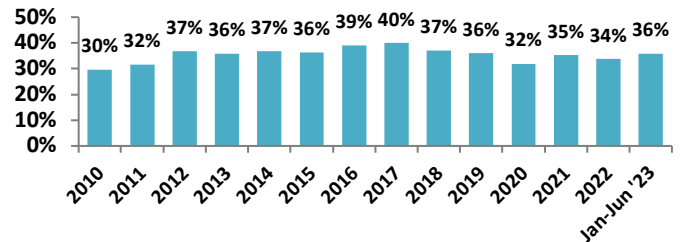
Benchmark 2
CT Medicaid Long-Term Care Expenditures



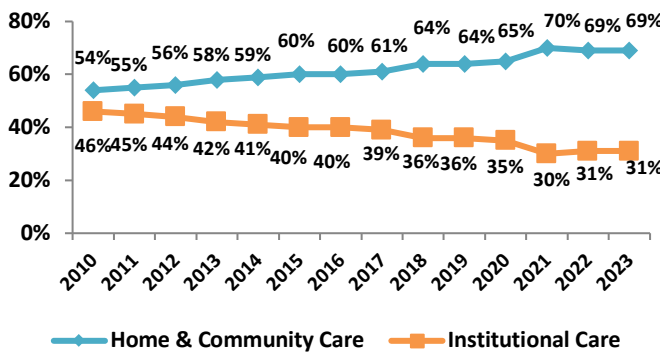
Benchmark 3
Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility



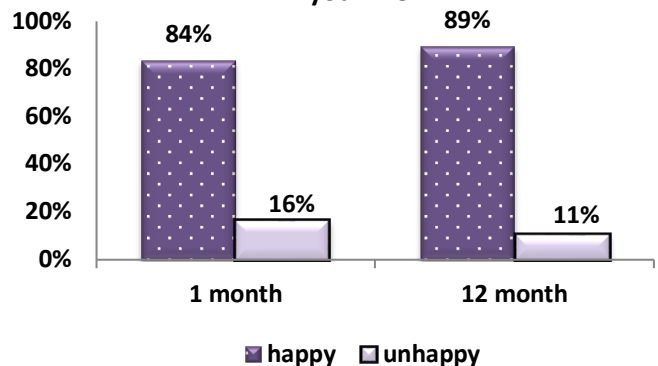
Benchmark 4
Percent of SNF admissions returning to the community within 6 months



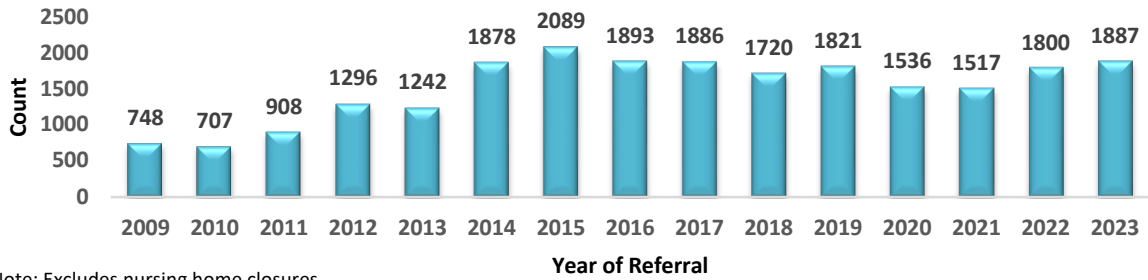
Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions



Happy or unhappy with the way you live your life

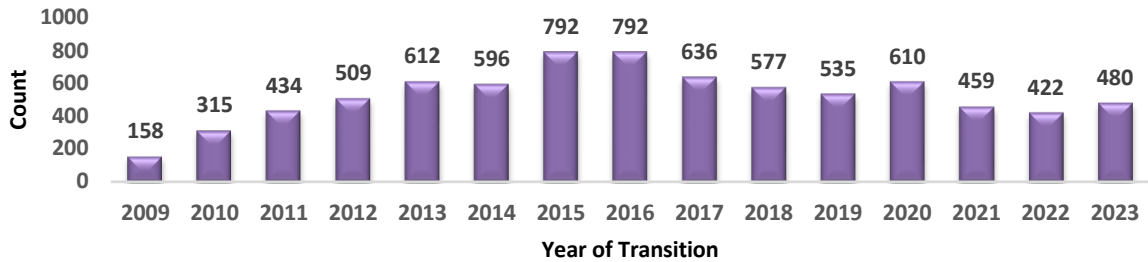


Total Number of Referrals Assigned to the Field by Year

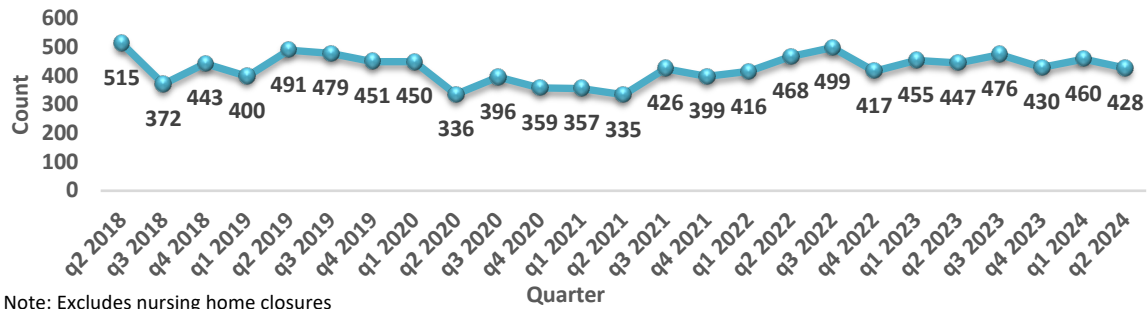


Note: Excludes nursing home closures

Total Number of Transitions by Year

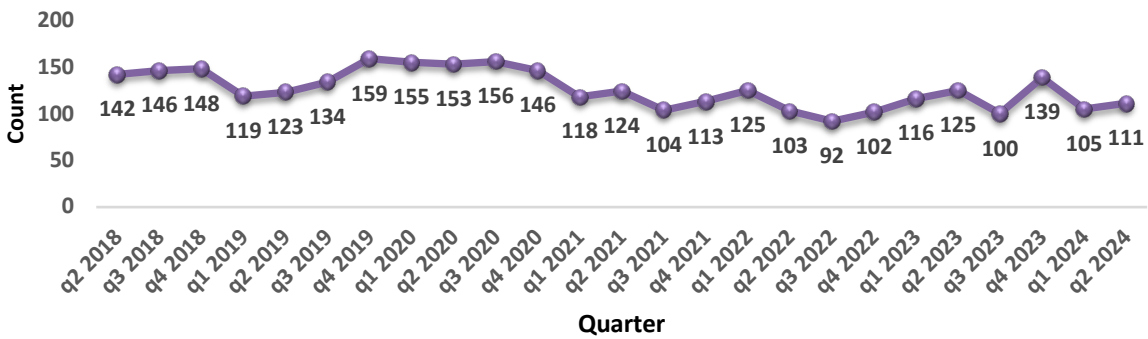


Referrals Assigned to the Field by Quarter

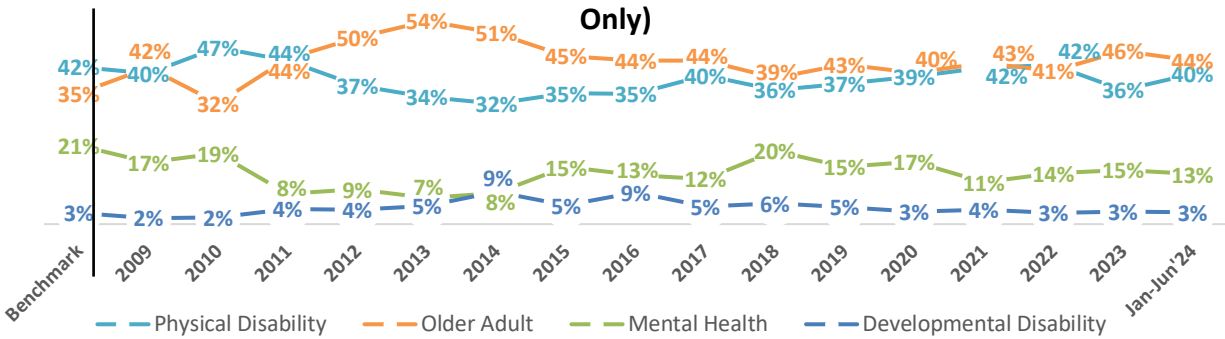


Note: Excludes nursing home closures

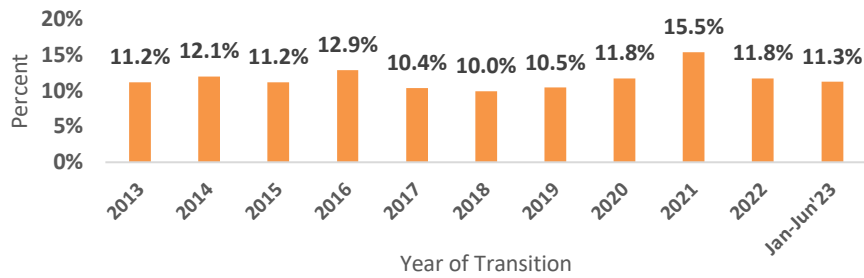
Number of Transitions by Quarter



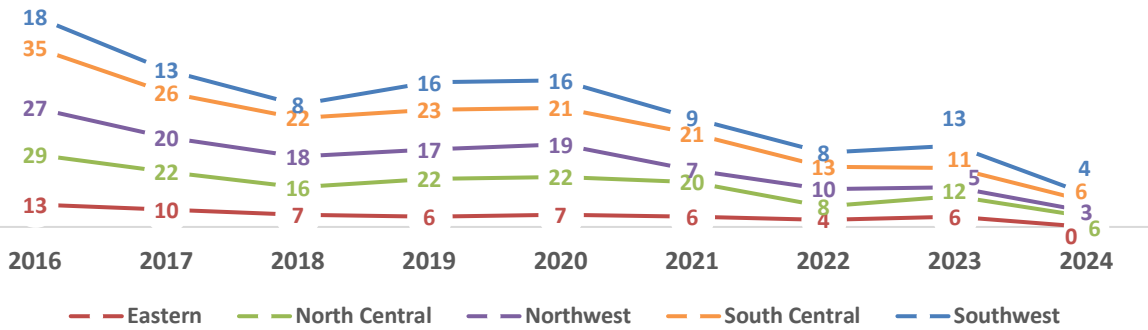
Target Population for Transitions by Year of Transition (Demonstration Only)



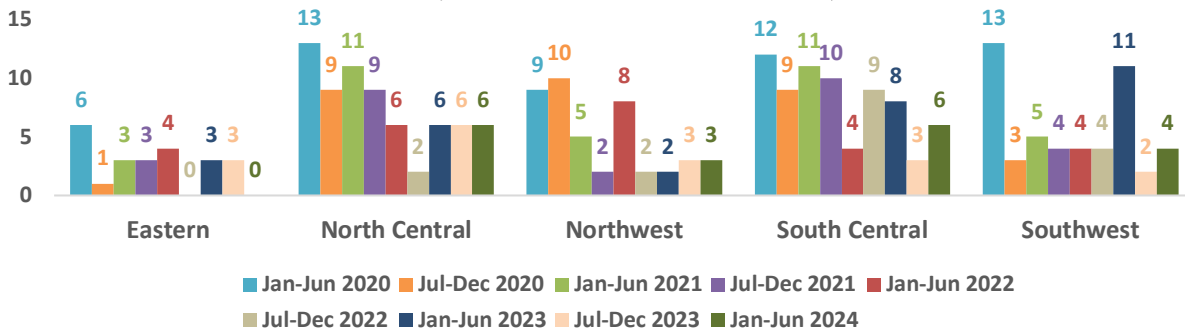
Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay



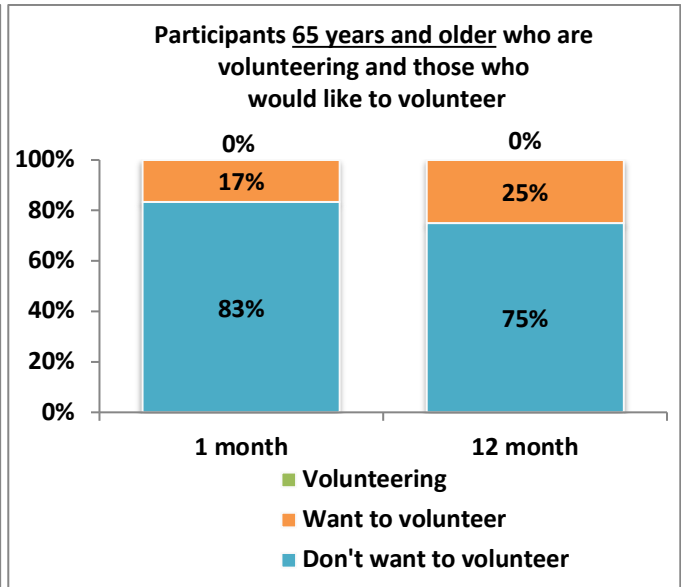
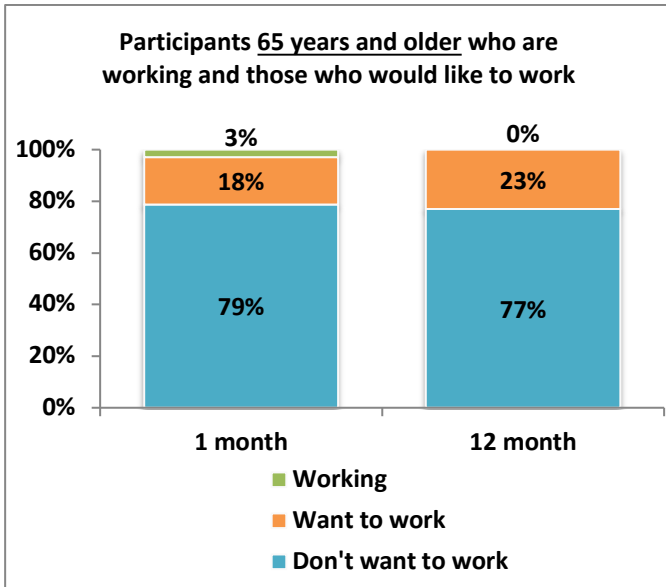
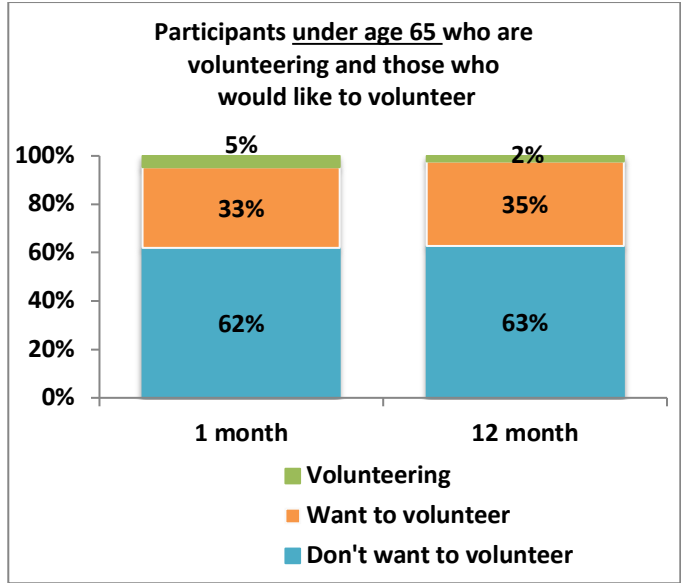
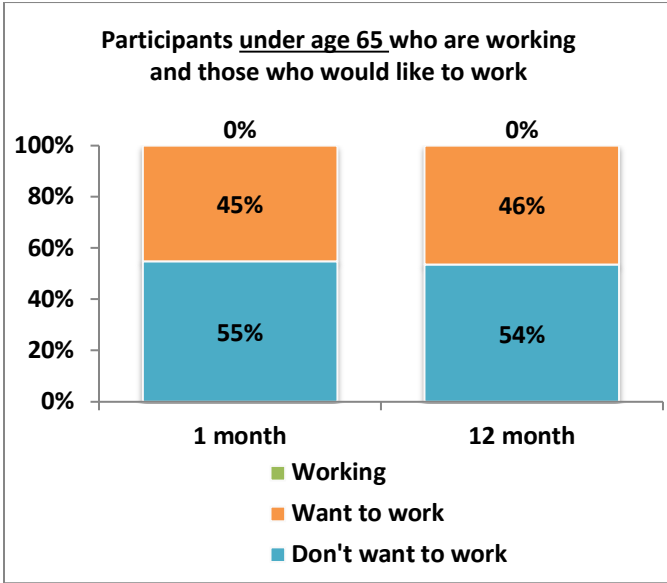
Number of Participants with Home Modifications by Year Approved and Region



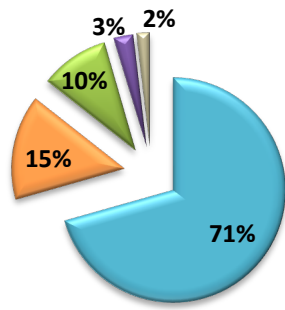
Number of Participants with Home Modifications per 6 Months



Participants who are Working and/or Volunteering (data 3/1/24-6/30/24)



Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 6/30/2024

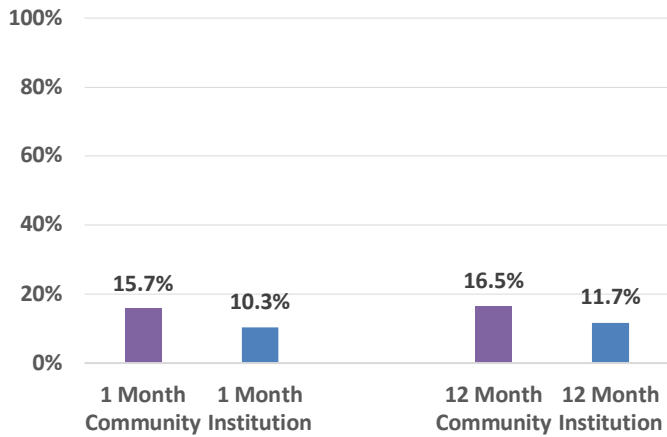


- Apartment Leased By Participant, Not Assisted Living
- Home Owned By Family Member
- Home Owned By Participant
- Apartment Leased By Participant, Assisted Living
- Group Home No More Than 4 People

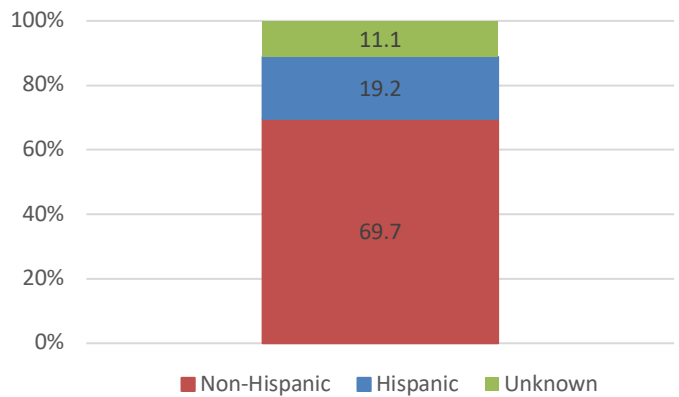
Race and Ethnicity for MFP Participants Transitioned 1/1/19 – 6/30/24 and for CT Medicaid Recipients in 2022

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

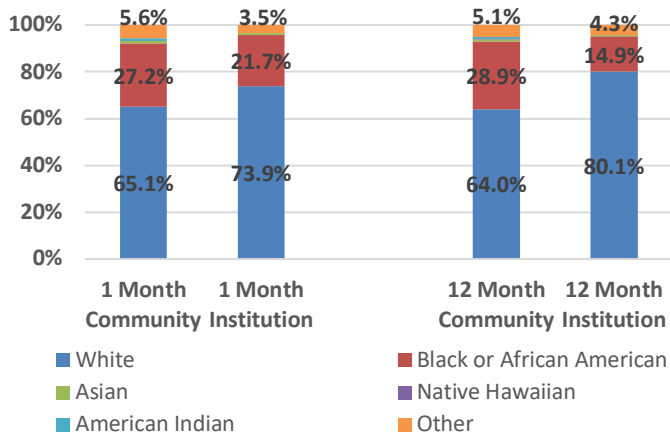
MFP Participants Who Are Hispanic



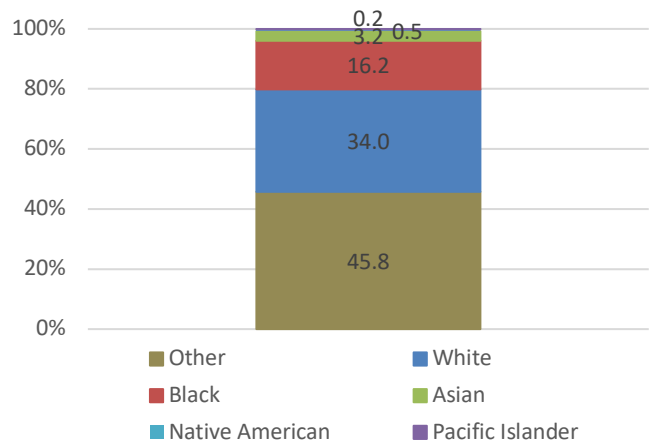
Reported Ethnicity for All CT Medicaid Recipients in 2022



MFP Participants' Self-Reported Race



Reported Race for All CT Medicaid Recipients in 2022

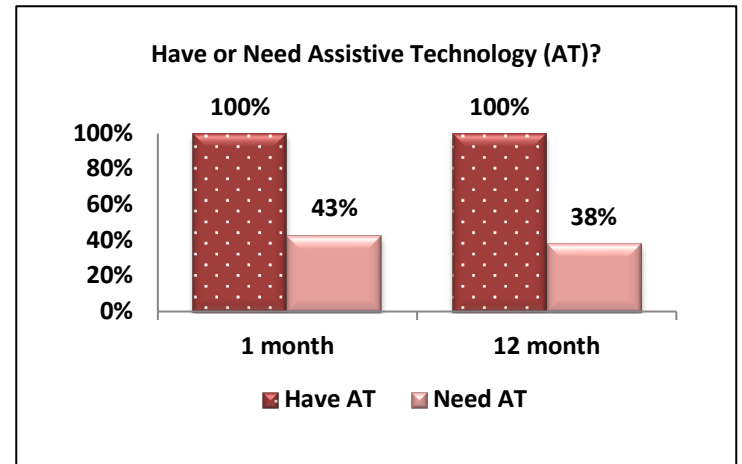
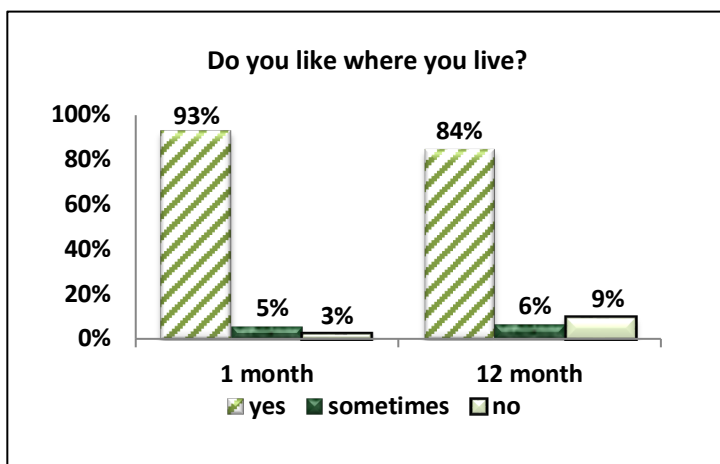
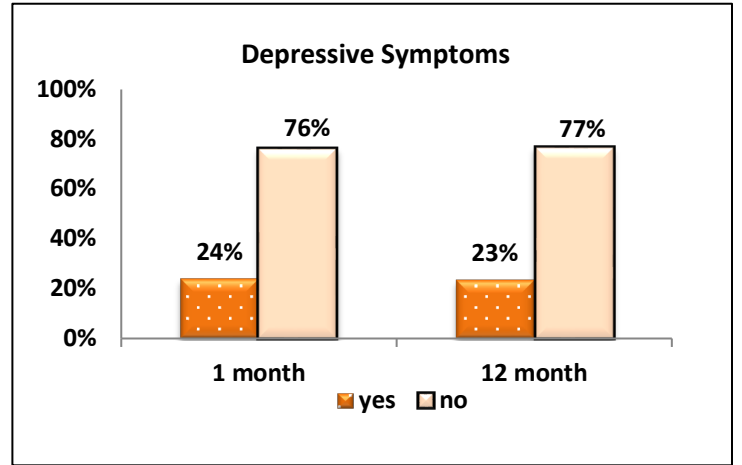
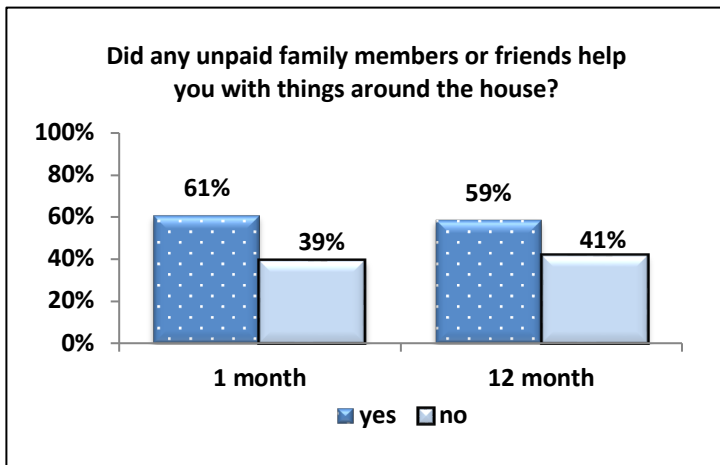
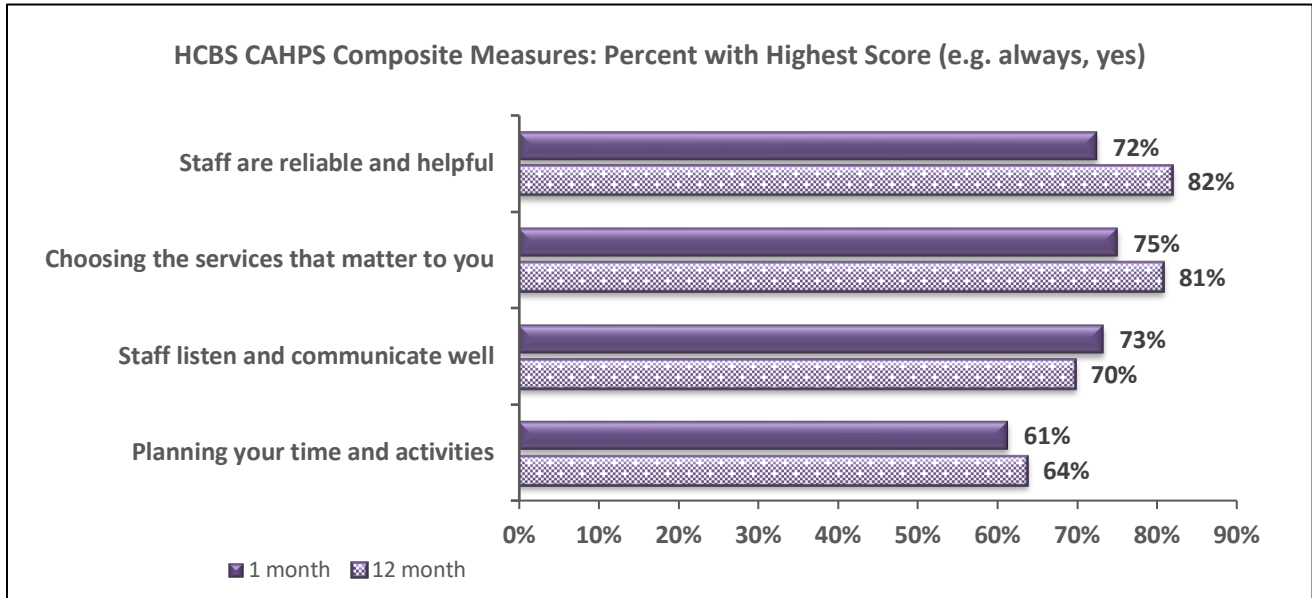


MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed from 4/1/24 - 6/30/24 (n=143)

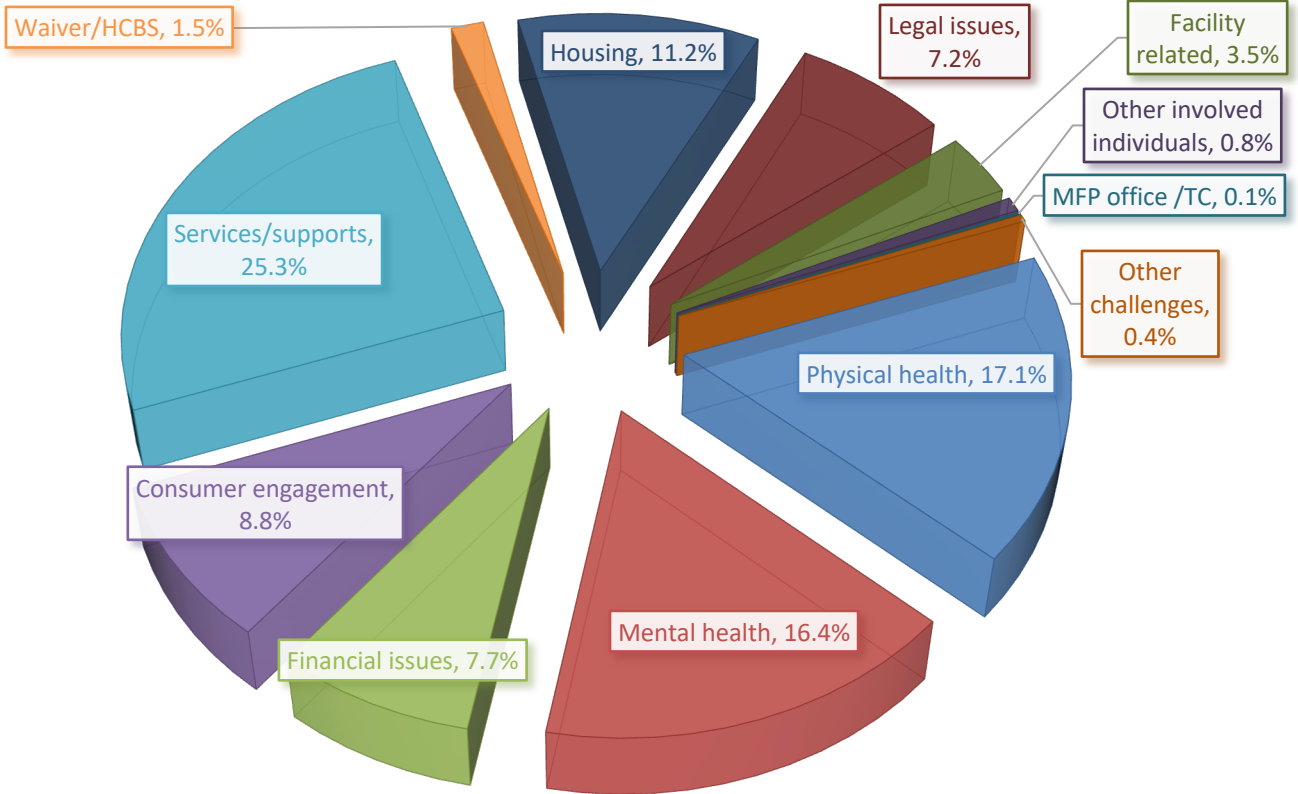
1 month interviews done 1 month after transition, n=78

12 month interviews done 12 months after transition, n=65

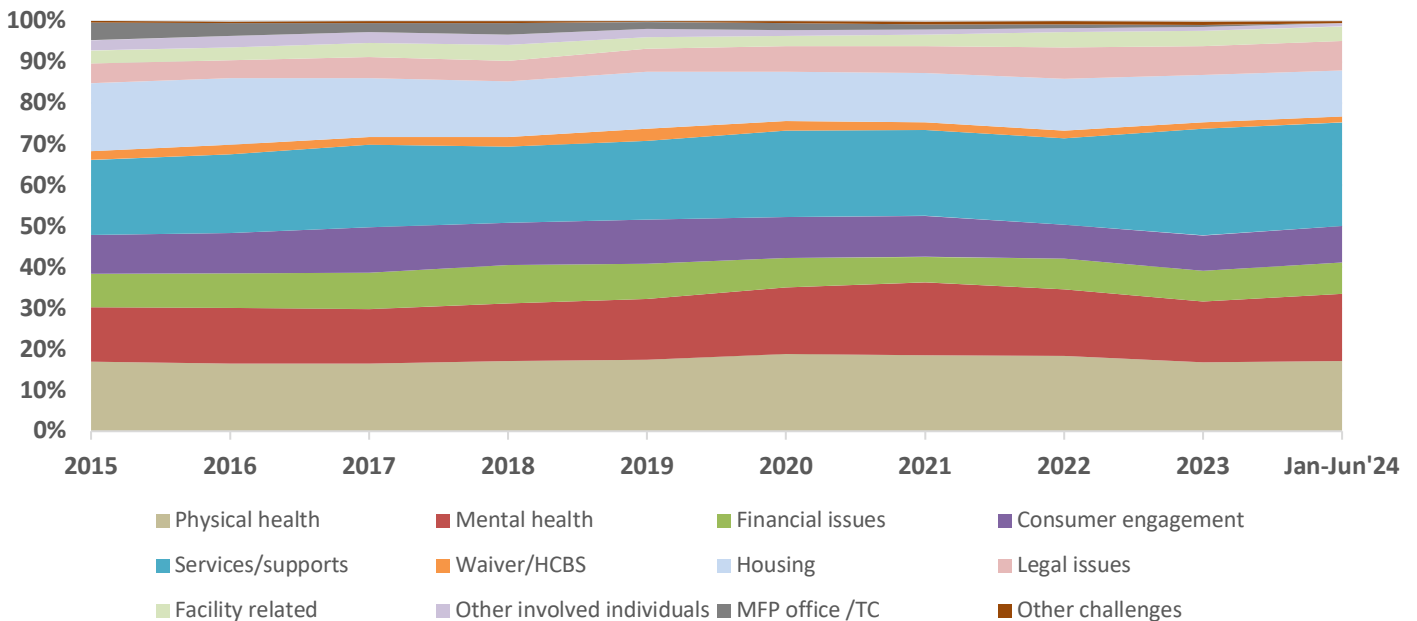


Challenges to Transition as Recorded by TCs and SCMs

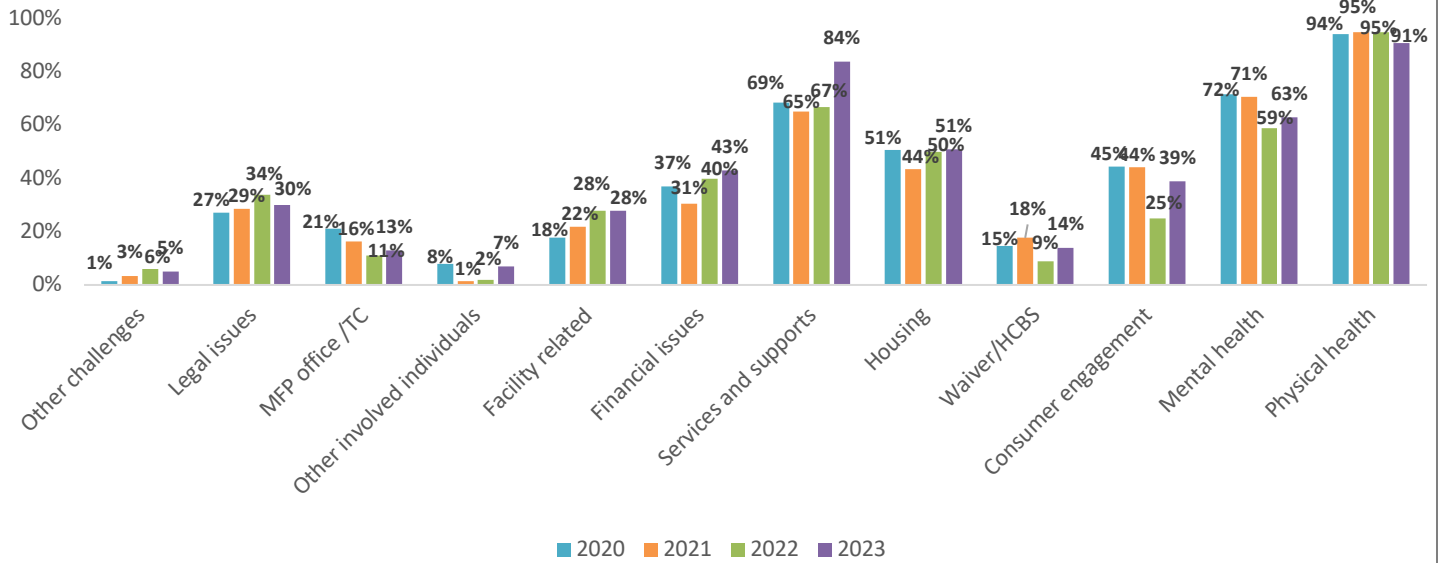
Transition Challenges for Participants Referred Jan-Jun 2024



Frequency of Transition Challenges by Year of Referral



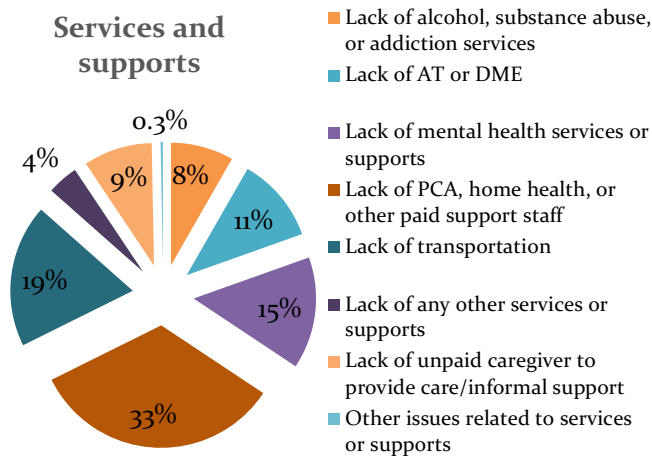
Participants with Each Challenge who Transitioned by Referral Year



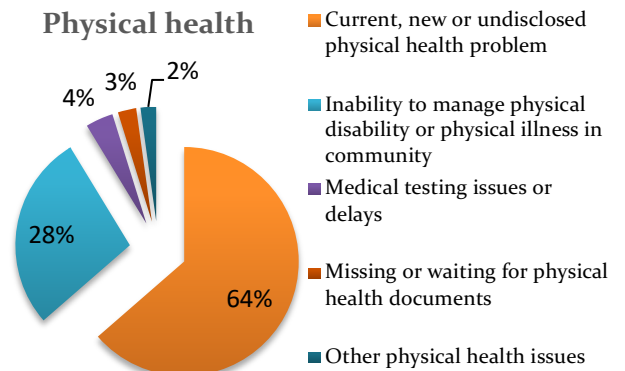
Types of Challenges for Referrals: 1/1/24 - 6/30/24

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

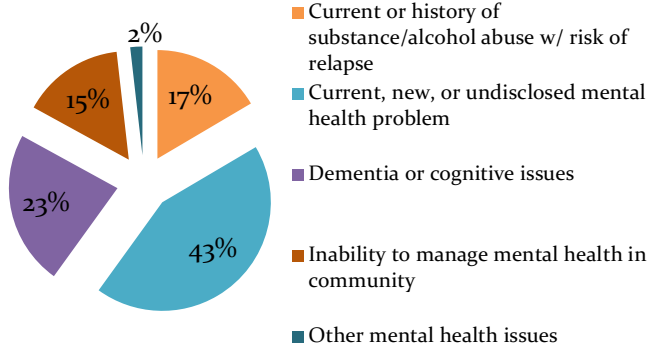
Services and supports



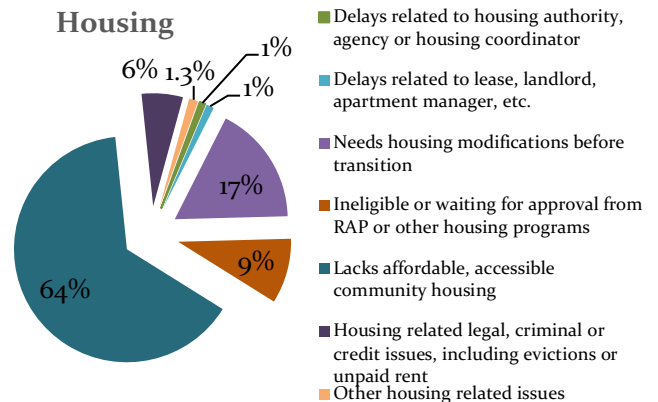
Physical health



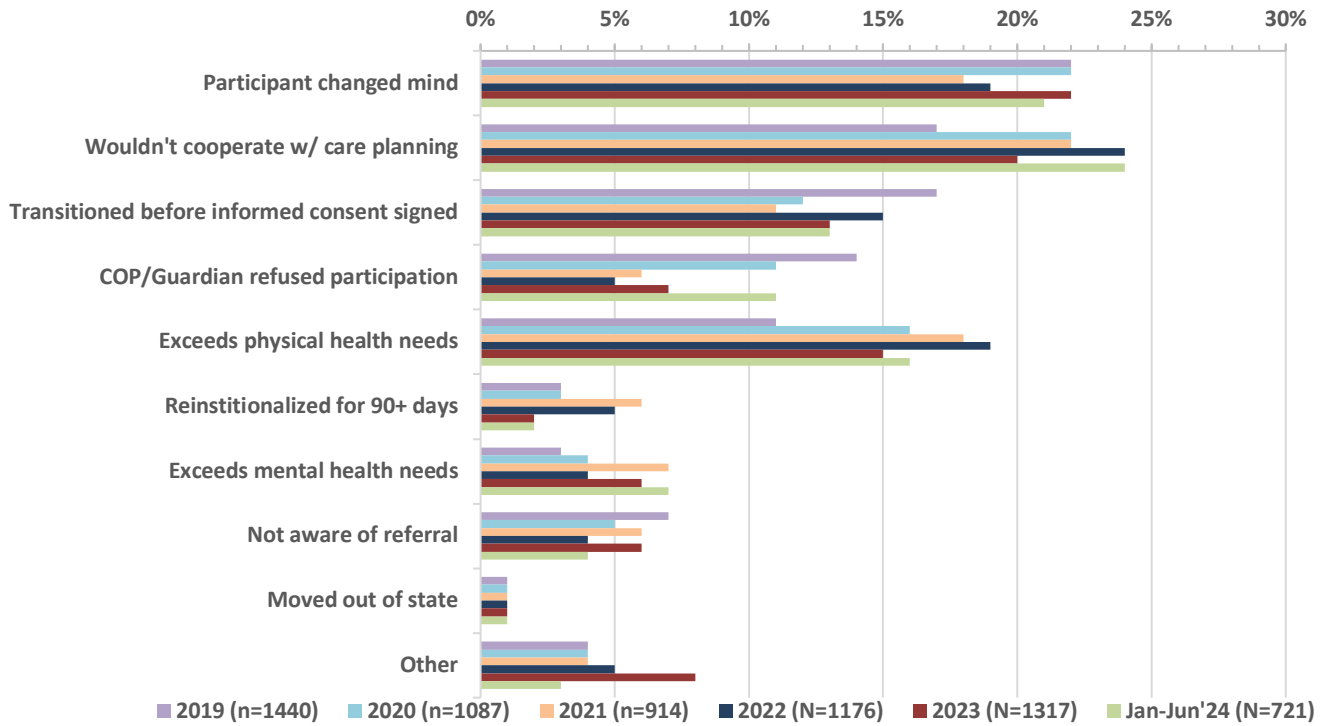
Mental health



Housing

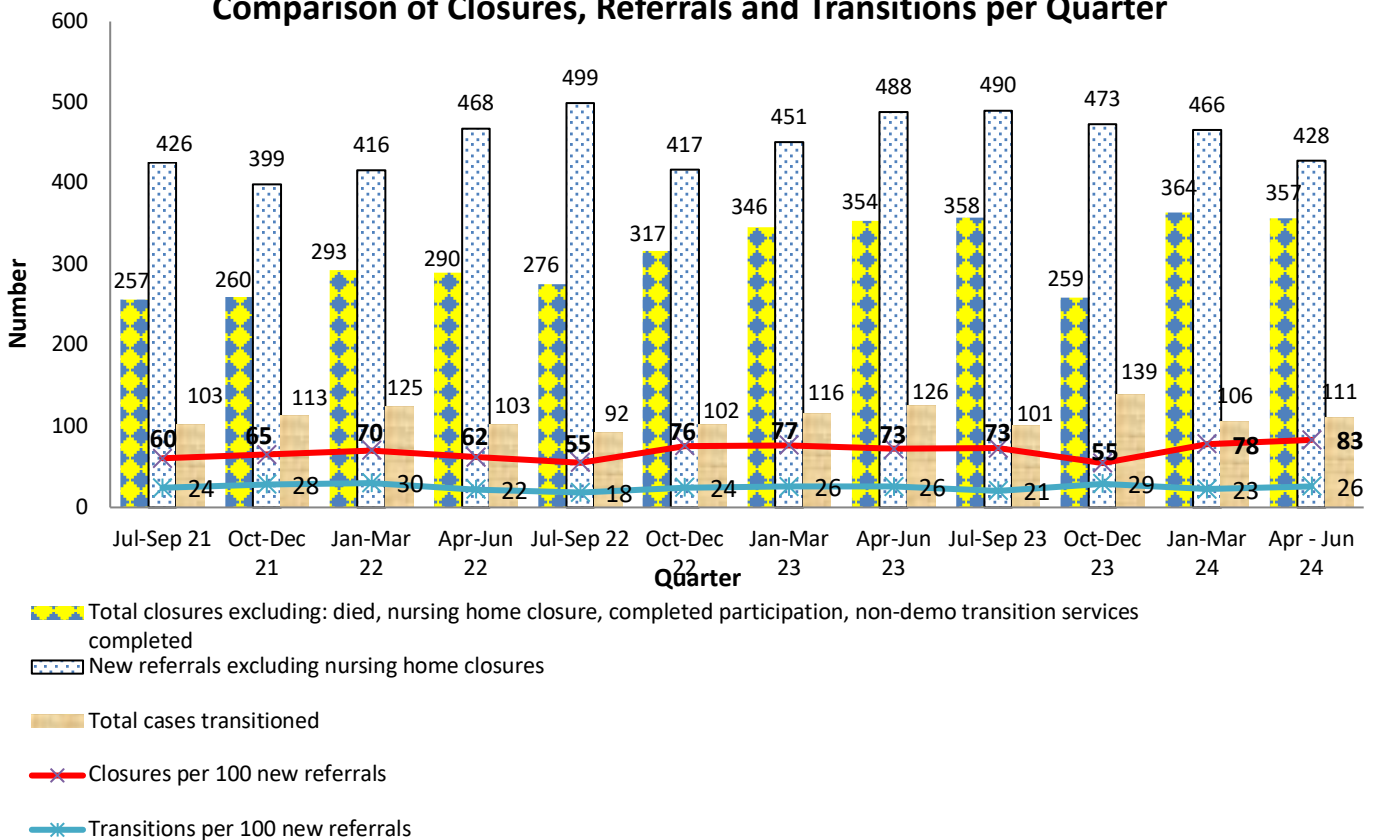


Frequency of Closure Reason by Year of Closure



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

Comparison of Closures, Referrals and Transitions per Quarter



Rosemarie's Story

The heart symbolizes many things for Rosemarie. This is a story about Rosemarie's own heart, the one that slowed so much she needed a Life Star helicopter and emergency surgery to reset its electricity with a pacemaker, and her emotional heart: how she is learning to live a new life after multiple major losses (sister, father, mother, boyfriend, brother-in-law, and her dog). She holds a Valentine's Day balloon, given to her by her wonderful aide, which reminds her of her sister.

Rosemarie was a med-certified community living specialist working with



Photo courtesy of Rosemaire

behaviorally and intellectually challenged adults in group home for the last sixteen years. She also volunteered with Special Olympics. "They gravitated to me and me to them." This was a physically demanding job, and she was working double shifts as she knew her clients needed her but became exhausted. At the urging of her boyfriend, she went to the ER with a "crick in her neck." It was much more serious! Everyone was amazed she was able to talk with barely a heartbeat, but she remembers the details of that day, especially the exciting ride in the helicopter to the hospital. After developing sepsis from the first pacemaker, she underwent another more extensive surgery to implant another pacemaker. For the next 6 months she was tethered to the IV pole for 20 hours a day to clear the infection.



Photo by Christine Bailey

Her heart "now had power," but she spent the next two years in a nursing facility learning how to walk and live again. At first, she was very discouraged and really thought she wasn't going to live. All of this was at the height of COVID, and she was unable to see her family for months. Helping her roommate who had dementia gave Rosemarie a purpose. Yet she was determined to leave the nursing home and worked very hard with the wonderful physical and occupational therapy team to regain her independence. Even before she learned about Money Follows the Person (MFP) through the facility social worker, she was very proactive in looking for places to live. Once she applied for MFP, she was connected to the housing coordinator. However, she had already been working with housing attorneys as she found an apartment because the landlord would not accept the housing voucher. She won her case and three months later she moved into her apartment. To this day, however, she is the only tenant whom they've accepted with the housing voucher. She credits the MFP transition coordinator and the care manager at doing a fantastic job to make the phone calls and help her realize her goal of moving to a new home. She would like others to know about MFP and if they are capable, to look on their own for apartments. She thinks that her actions and her determination made the difference to move out of the nursing facility. She now lives close to her daughter, brother, nieces and grandchildren.

Living alone in her new environment, her biggest adjustment is the quiet. She became accustomed to the noise in the nursing facility. The quiet also meant she needed to work through her grief. With monthly professional support she is doing this difficult work. She has reduced the number of medications she's taking with the goal of further reducing them. After the first aide did not work out, the second aide was a great fit. "We are like 2 peas in a pod." Since Rosemarie does not drive, her aide drives her to appointments, shopping and around town to enjoy nature. She is also walking much more, only needing the rollator for longer distances. She has made tremendous progress. Last year she was still learning to walk again. When she watches the beautiful sunset view over the river outside her window, she feels only gratitude.

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