

CT Money Follows the Person Report

Quarter 1: January 1 - March 31, 2025

UConn Health, Center on Aging

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

MFP Benchmarks

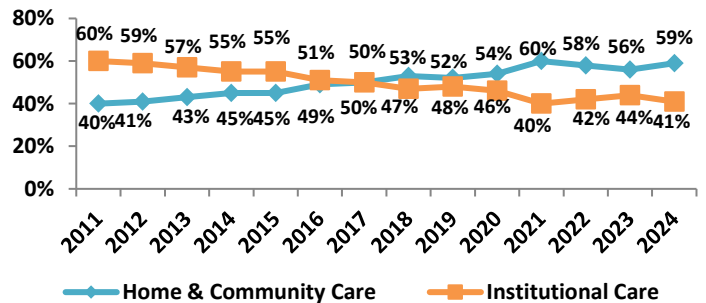
- 1) Transition 5200 people from qualified institutions to the community
- 2) Increase dollars to home and community based services
- 3) Increase hospital discharges to the community rather than to institutions
- 4) Increase probability of returning to the community during the six months following nursing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

Benchmark 1: Total Transitions = 8,472

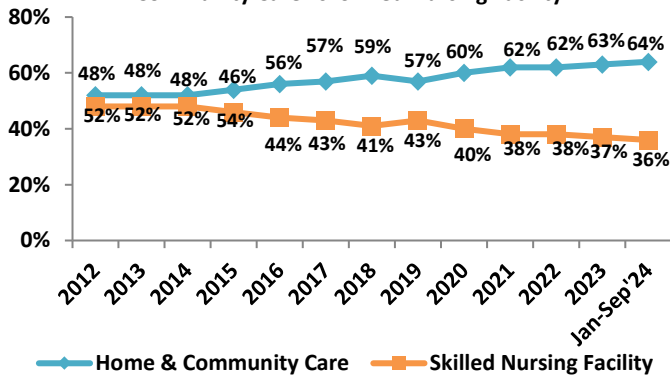
Demonstration = 7,923 (94%)

Non-demonstration = 549 (6%)

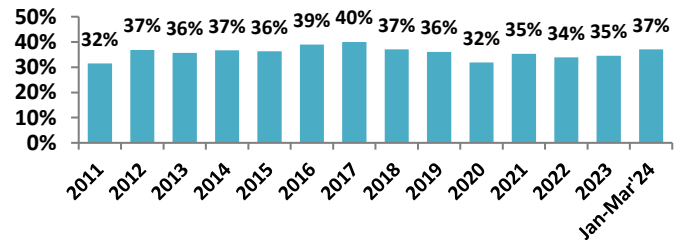
Benchmark 2 CT Medicaid Long-Term Care Expenditures



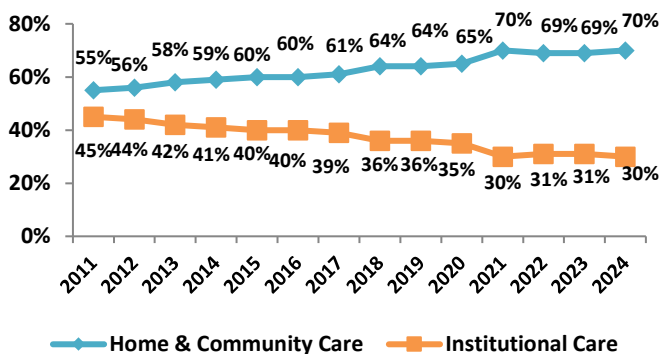
Benchmark 3 Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility



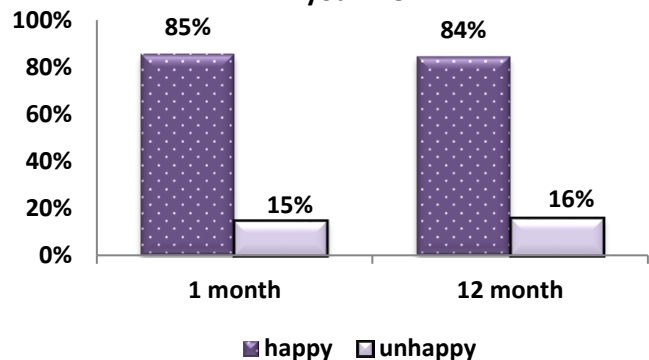
Benchmark 4* Percent of SNF admissions returning to the community within 6 months



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

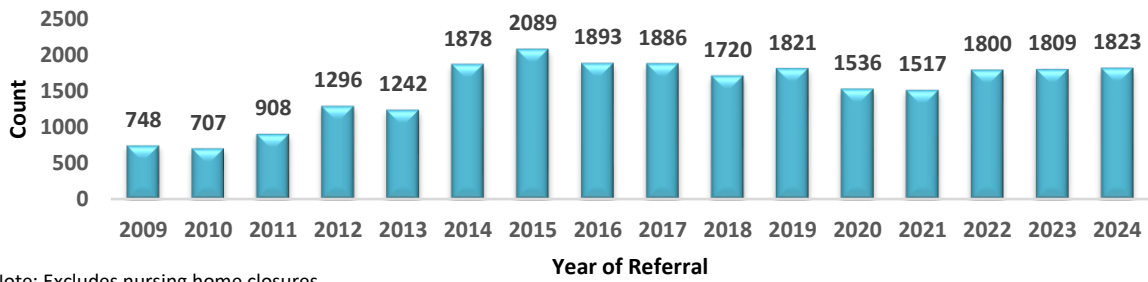


Happy or unhappy with the way you live your life

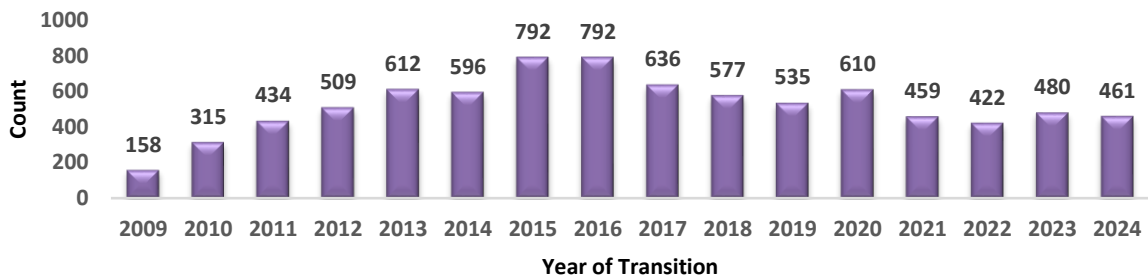


* = Not updated for Q1 2025

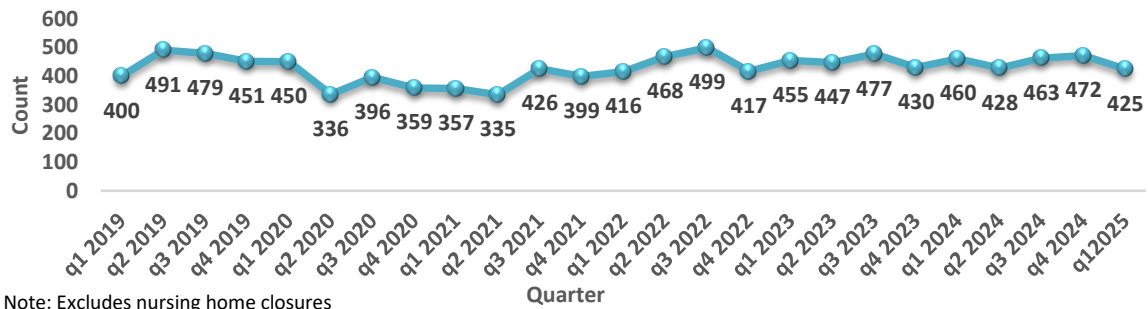
Total Number of Referrals Assigned to the Field by Year



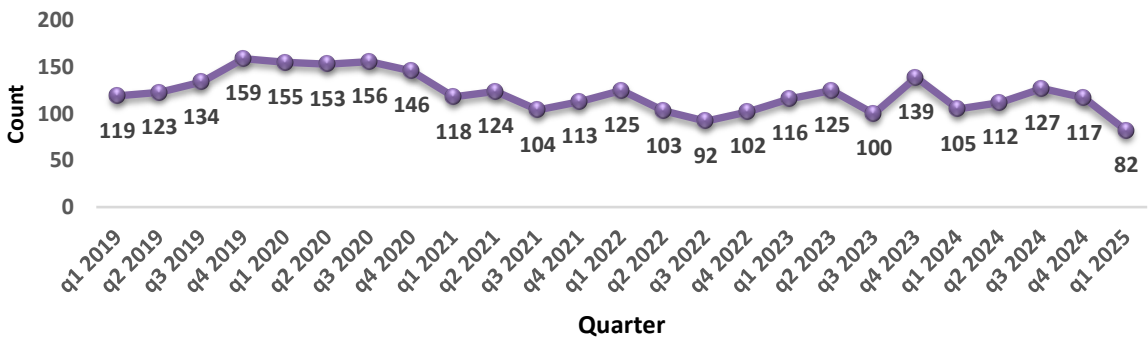
Total Number of Transitions by Year



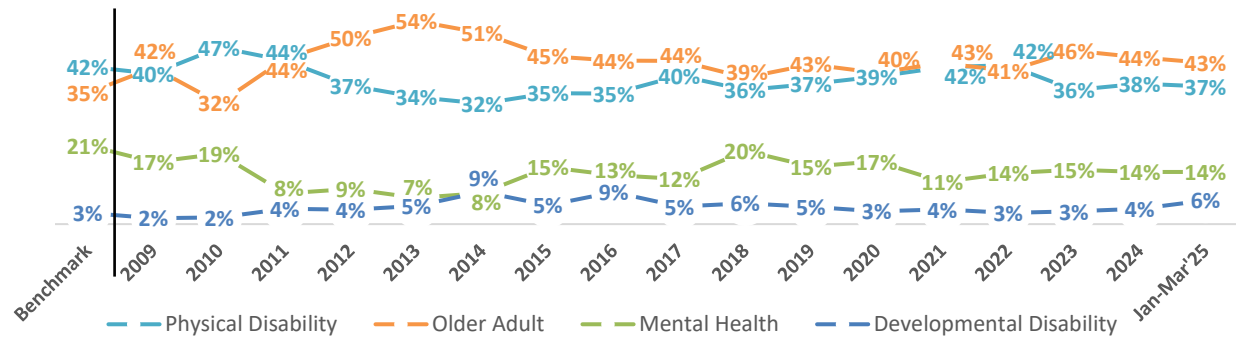
Referrals Assigned to the Field by Quarter



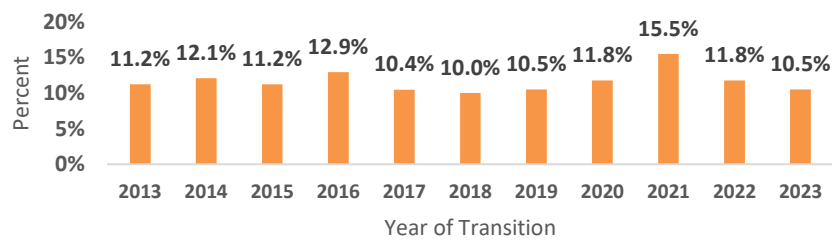
Number of Transitions by Quarter



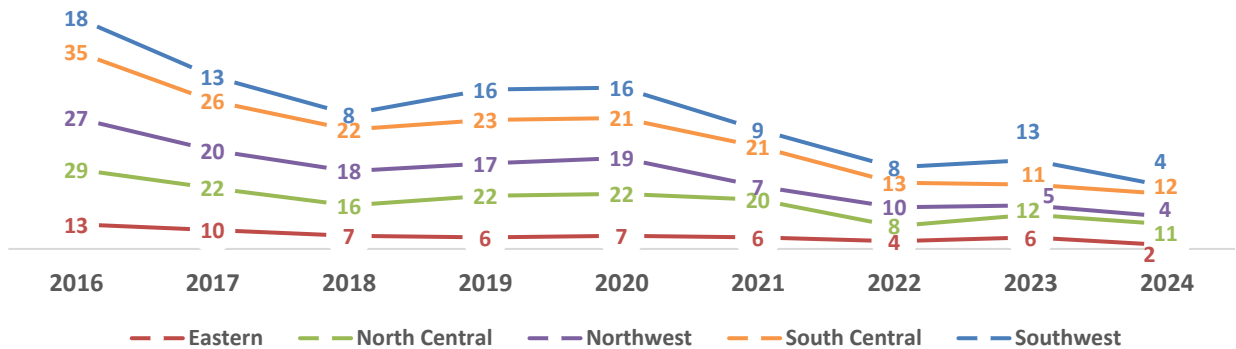
Target Population for Transitions by Year of Transition (Demonstration Only)



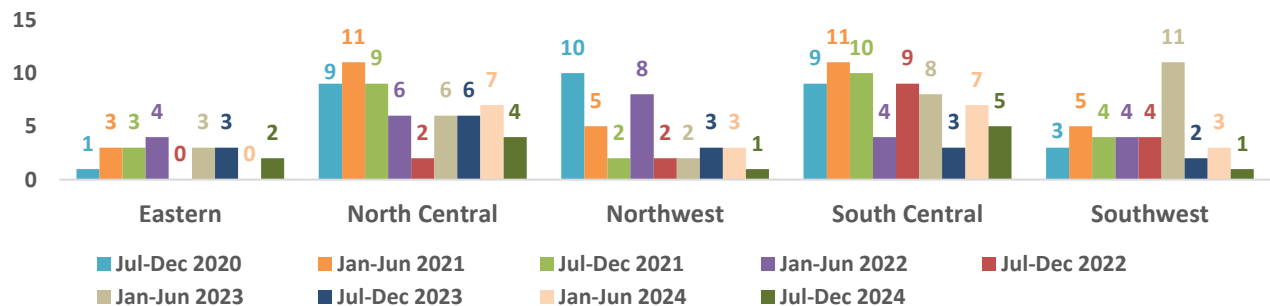
Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay *



Number of Participants with Home Modifications by Year Approved and Region *



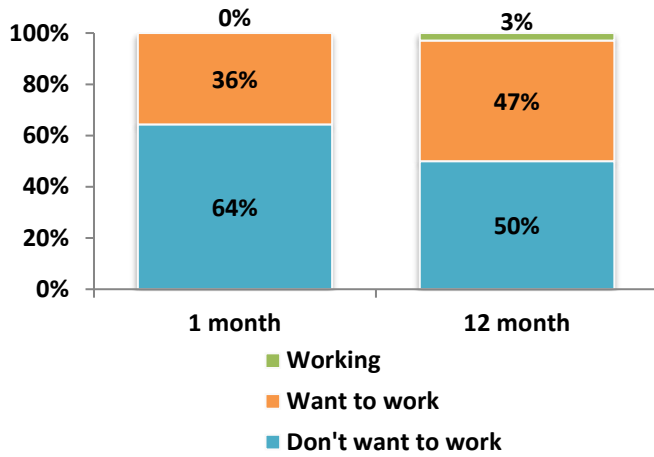
Number of Participants with Home Modifications per 6 Months *



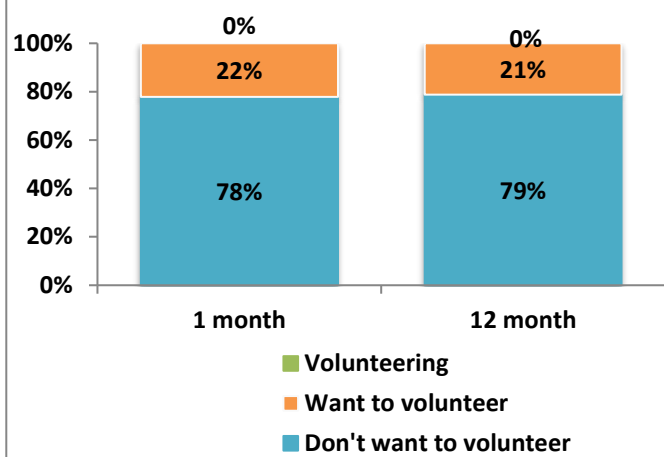
* = Not updated for Q1 2025

Participants who are Working and/or Volunteering (data 1/1/25-3/31/25)

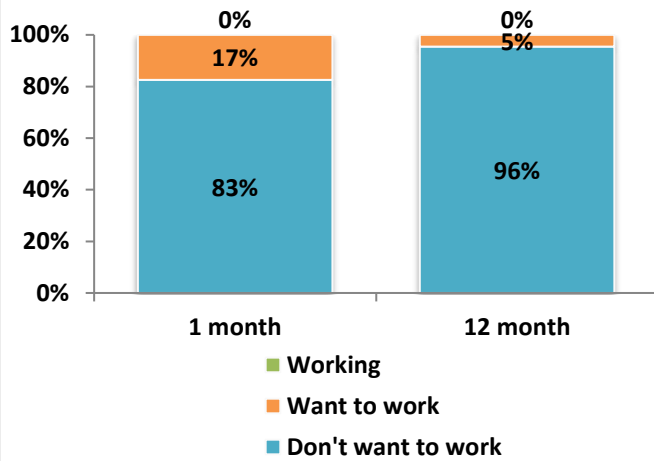
Participants under age 65 who are working and those who would like to work



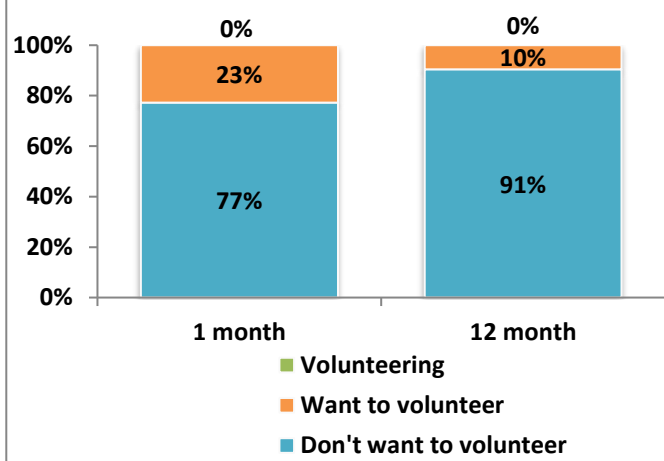
Participants under age 65 who are volunteering and those who would like to volunteer



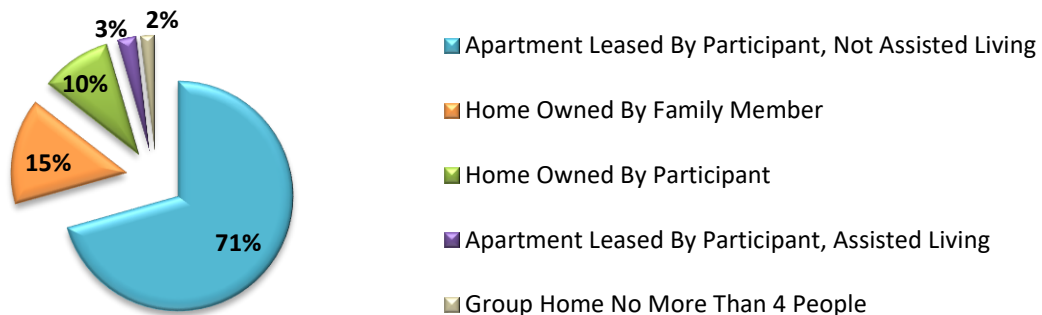
Participants 65 years and older who are working and those who would like to work



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



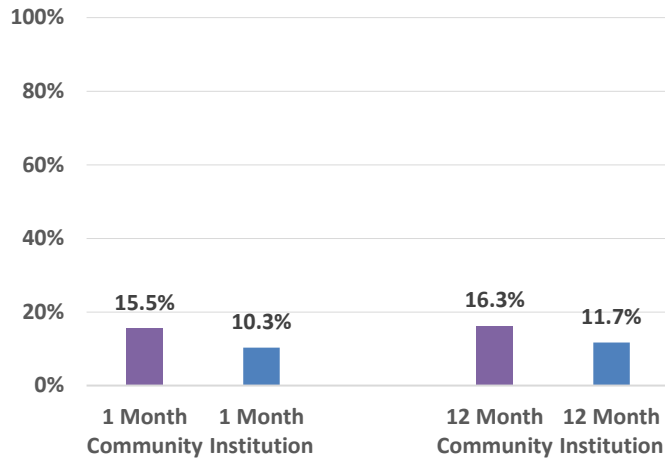
Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 3/31/2025



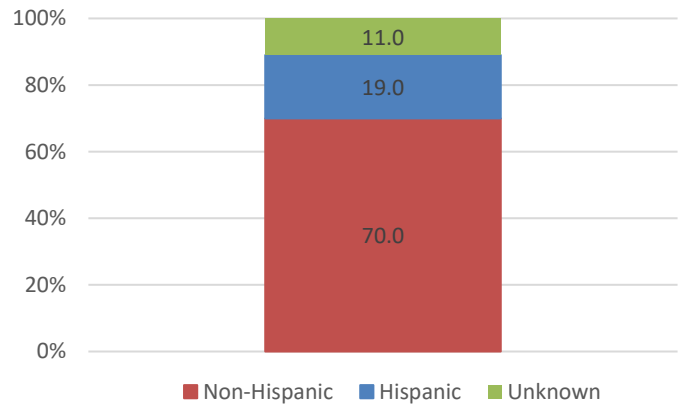
Race and Ethnicity for MFP Participants Transitioned 1/1/19 – 3/31/25 and for CT Medicaid Recipients in 2023

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

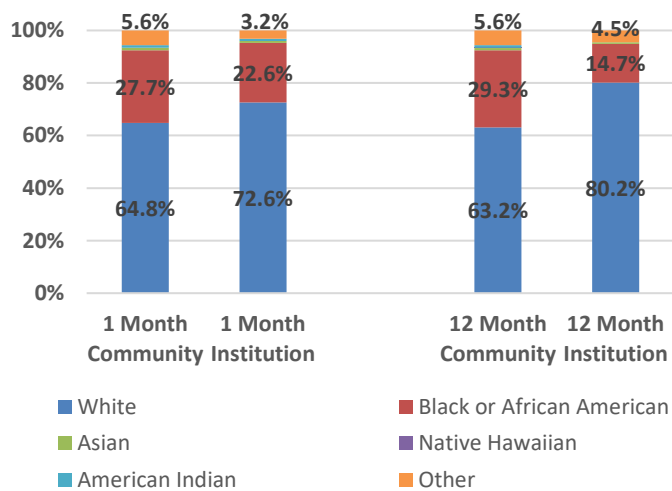
MFP Participants Who Are Hispanic



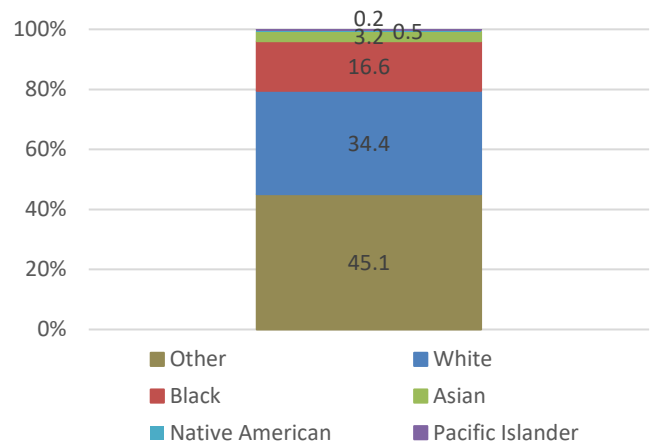
Reported Ethnicity for All CT Medicaid Recipients in 2023



MFP Participants' Self-Reported Race



Reported Race for All CT Medicaid Recipients in 2023



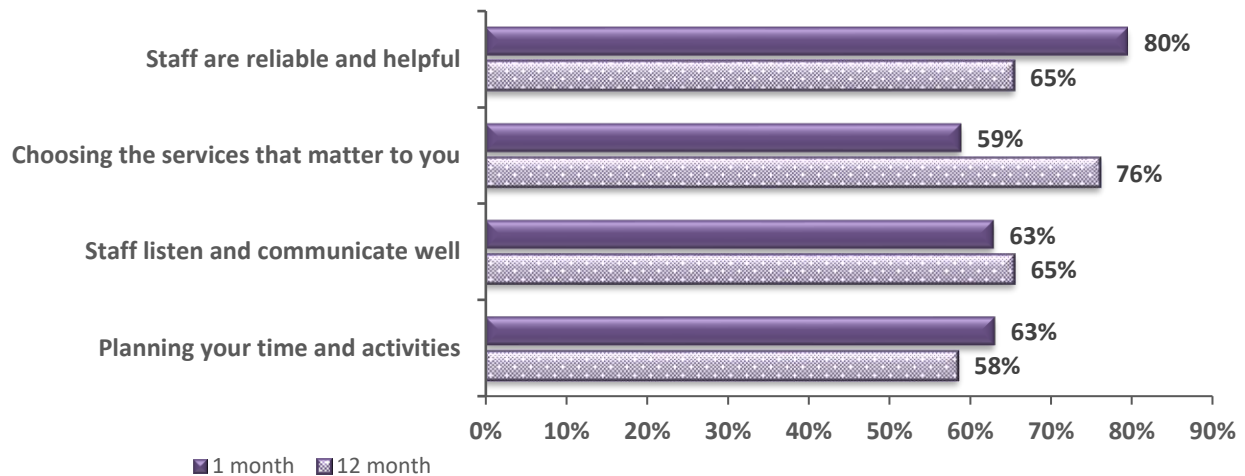
MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed from 1/1/25 - 3/31/25 (n=116)

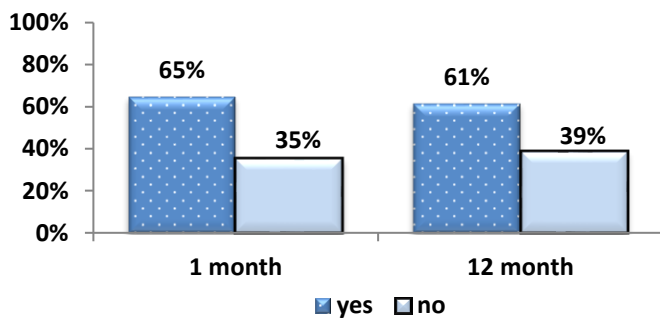
1 month interviews done 1 month after transition, n=53

12 month interviews done 12 months after transition, n=63

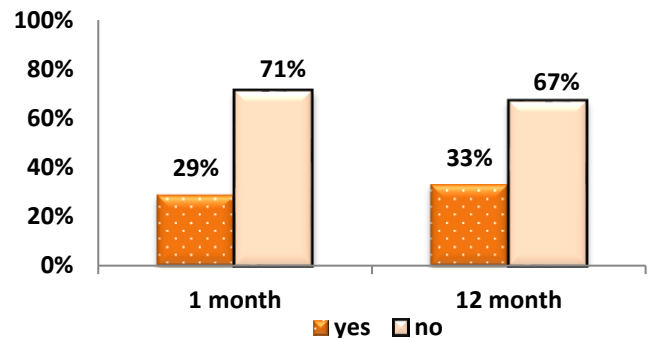
HCBS CAHPS Composite Measures: Percent with Highest Score (e.g. always, yes)



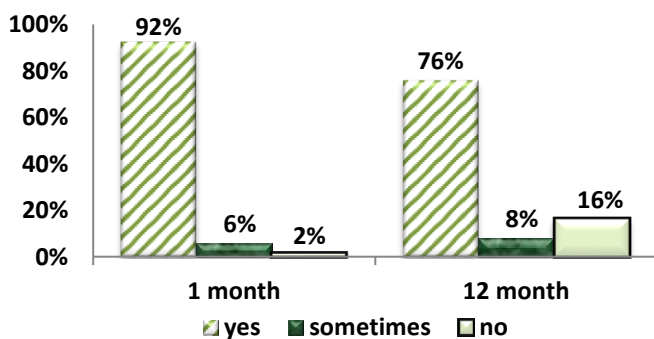
Did any unpaid family members or friends help you with things around the house?



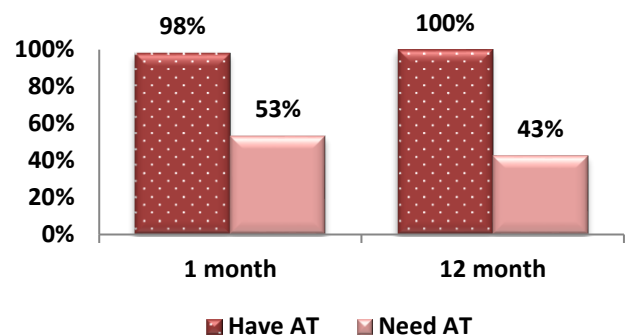
Depressive Symptoms



Do you like where you live?

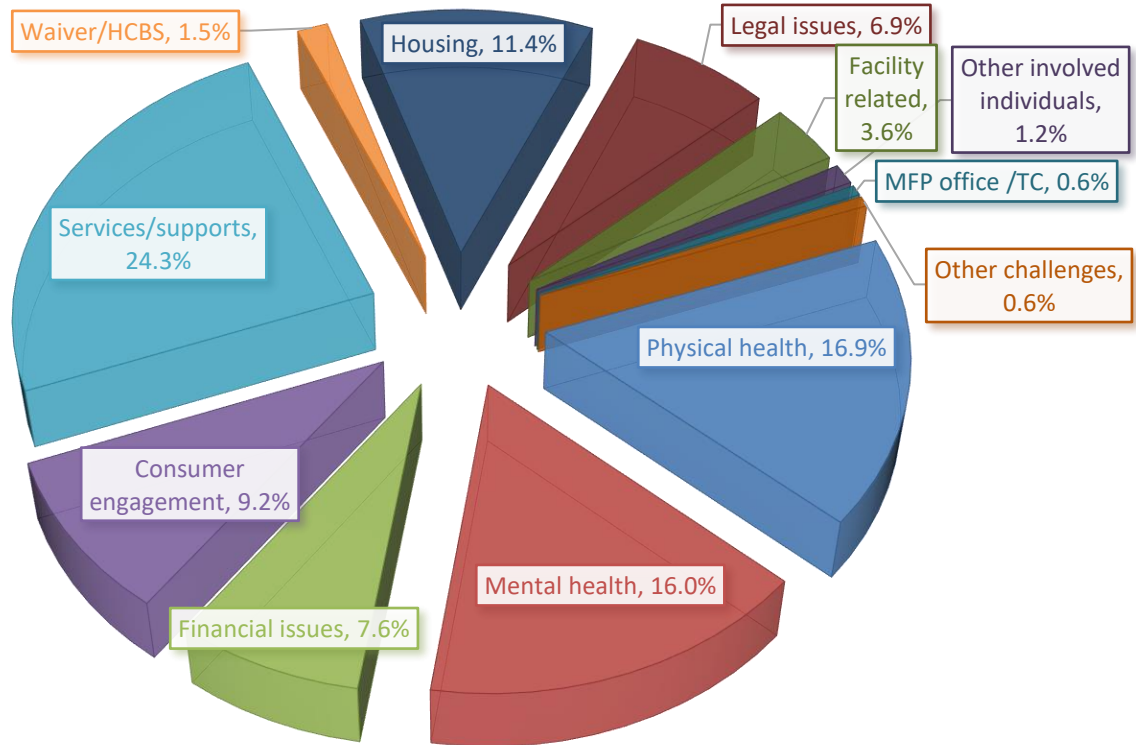


Have or Need Assistive Technology (AT)?

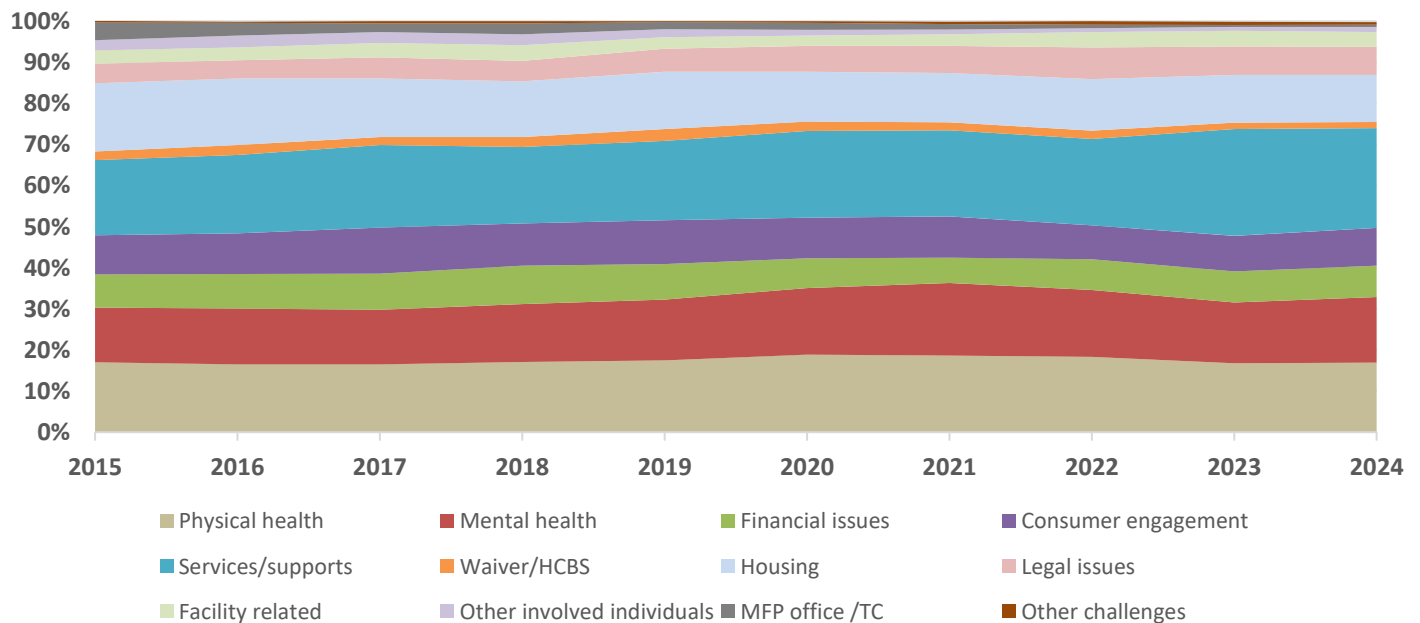


Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Dec 2024 *

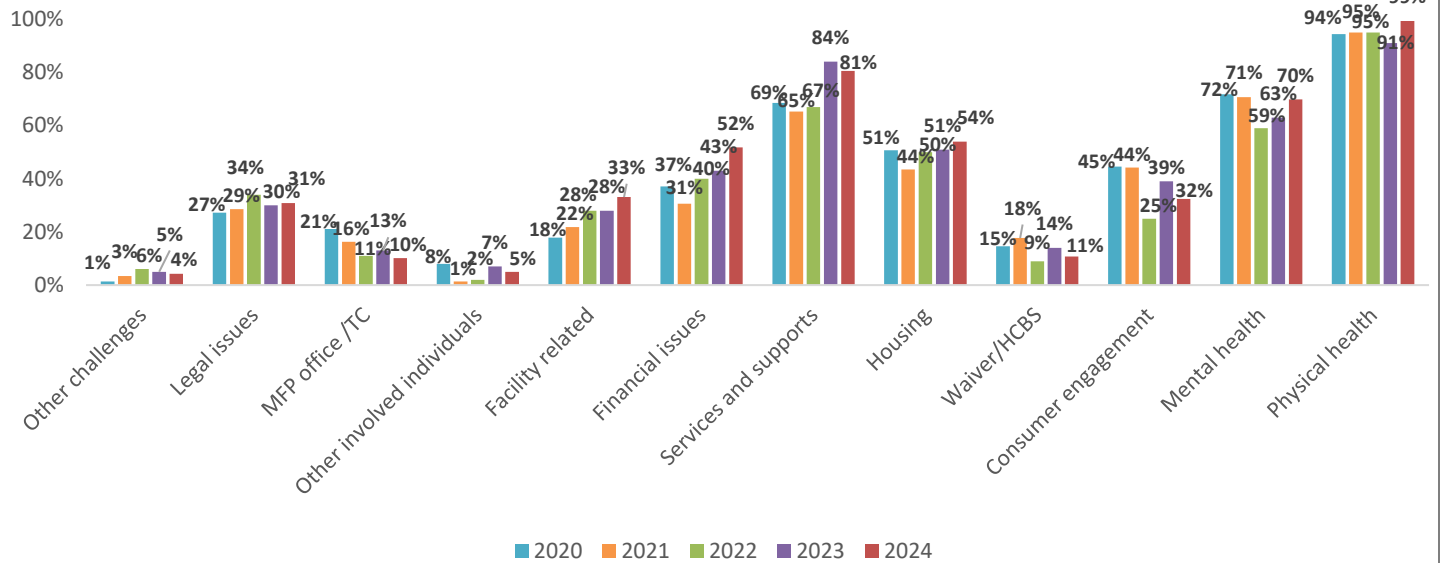


Frequency of Transition Challenges by Year of Referral *



* = Not updated for Q1 2025

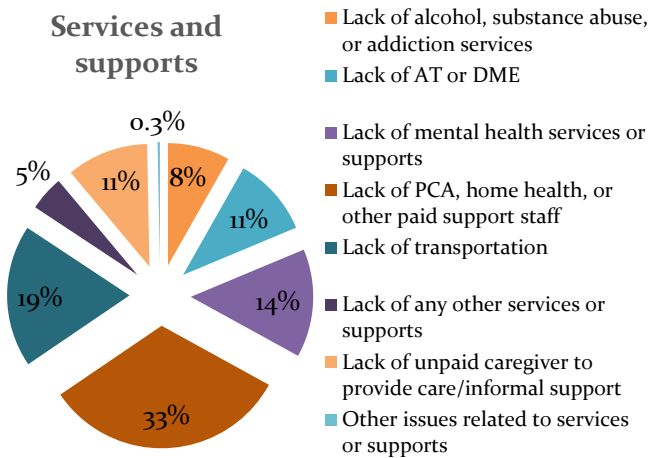
Participants with Each Challenge who Transitioned by Referral Year *



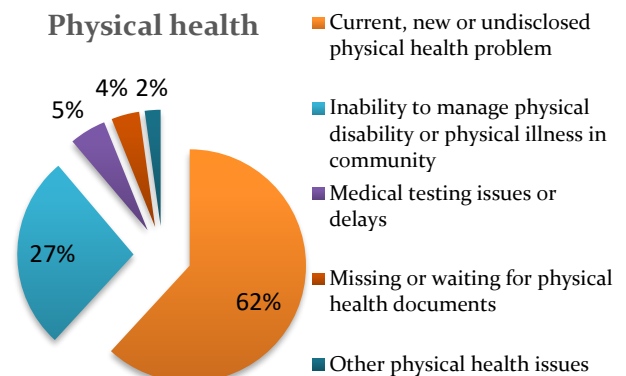
Types of Challenges for Referrals: 1/1/24 - 12/31/24 *

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

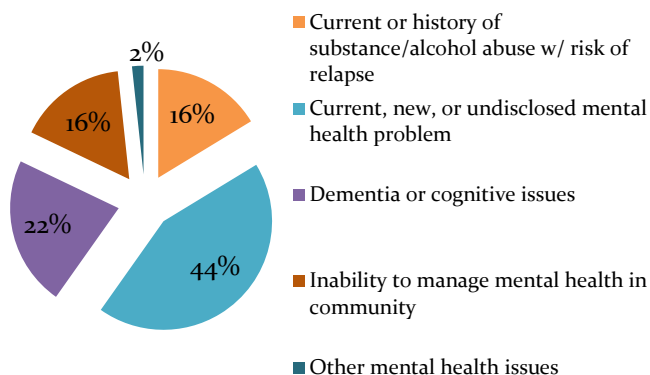
Services and supports



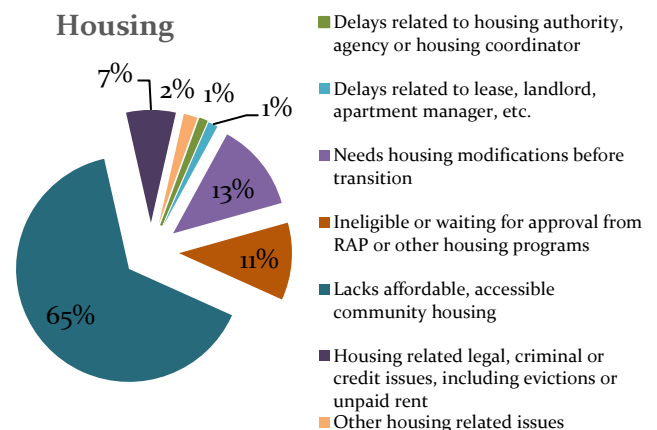
Physical health



Mental health

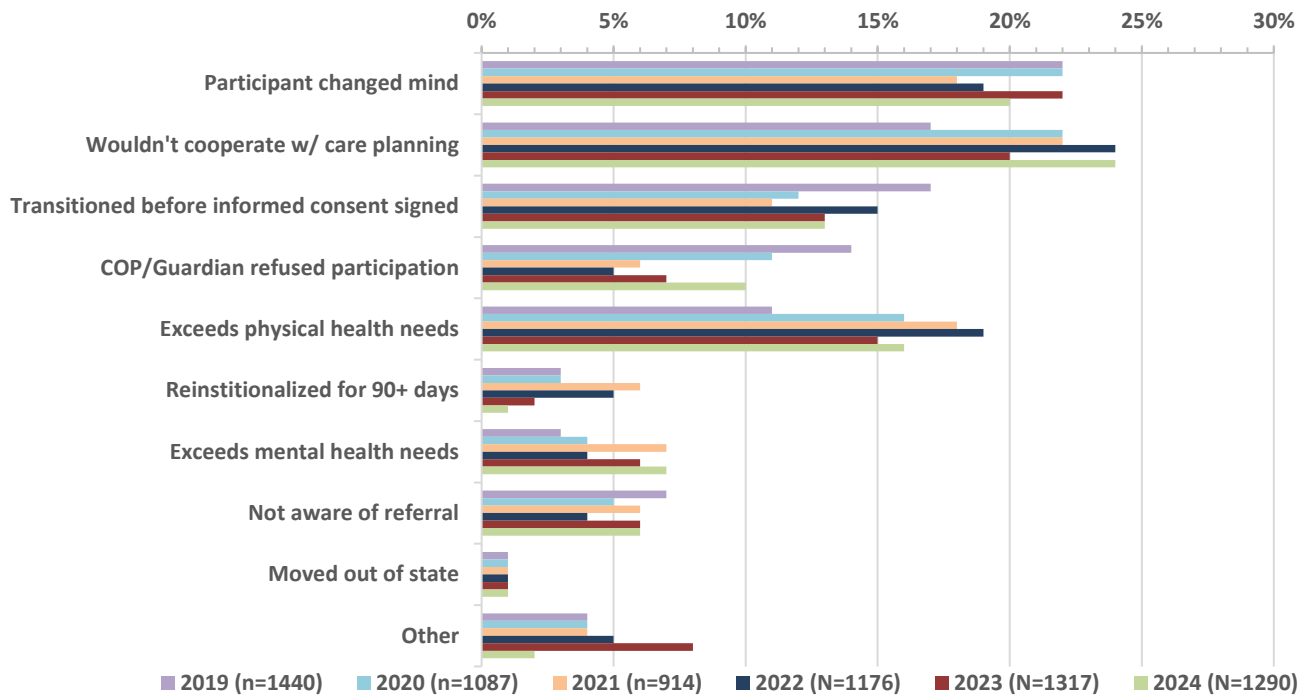


Housing



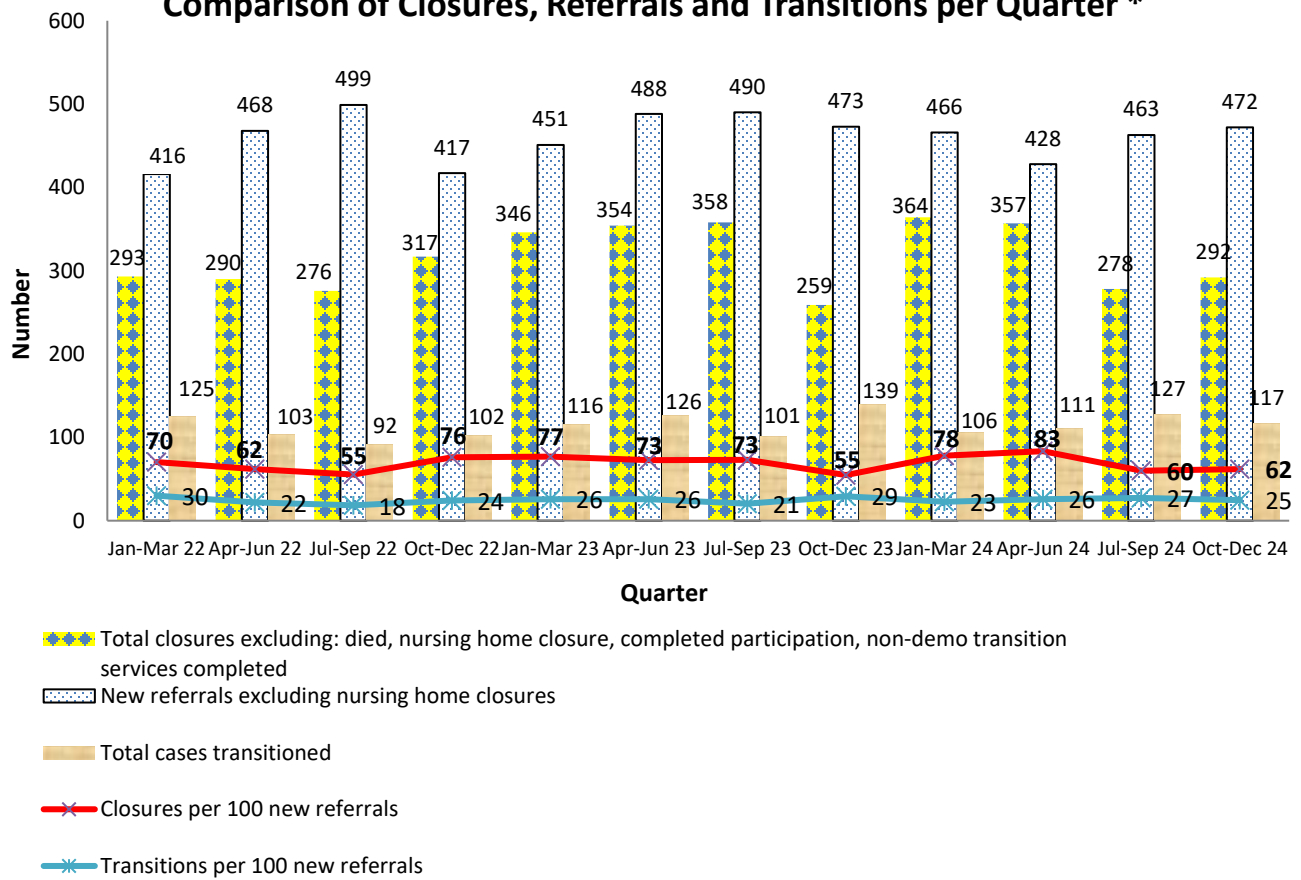
* = Not updated for Q1 2025

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 *



* = Not updated for Q1 2025

Gary's Story

Learning when to fight and when to let the little things go have been among Gary's greatest life lessons. His whole demeanor has changed from being angry and a worry wort most of the time to being more calm and accepting after surviving many losses. He owned his own business for 30 years and built his own home, but then came a divorce, the sale of the home, and a move with a new job which was going well, but ended abruptly when that business closed its doors. Starting over in a familiar town, renting a basement apartment from one of his sisters, he learned how to make surgical stents, which ironically would later be used to save his leg. When dizziness and falls occurred at work, he was let go on good terms hoping to return when his health improved. An emergency room visit and hospital stay in 2020 revealed his worsening symptoms were due to complications from COVID. His rehabilitation was not progressing due to his unsteady gait, falls, a wound on his foot, and a blood clot that went undiagnosed at the nursing home. He spent two weeks in the ICU and finally received great medical care that saved his leg from a life-threatening gangrene infection.

After almost three years in a nursing home, he gained 80 pounds from being overmedicated and in a wheelchair. He was told by the nursing home they did not have the staff to get him back on his feet and that he would never leave. Gary's reply, "We'll see about that!" Wanting to get moving and leave the nursing home, Gary advocated for himself by finding that he could receive physical therapy and transportation with the doctor's order at a nearby hospital. When the nursing home staff learned about this, they now agreed to provide PT. He experienced both fantastic, caring staff, like the nurses and aides on the day shift and the physical therapists, and terrible staff at other times. Little by little, he improved. A nursing home social worker referred him to Money Follows the Person (MFP). The MFP specialized care manager, transition coordinator and housing coordinator worked with Gary to collect the necessary documents and find a new place to live. This took much longer than expected. When the housing coordinator showed him a photo of the apartment, he accepted and moved even though it was not easily accessible on a 2nd floor. He received the shower chair to help him transfer safely. MFP provided a bed, towels, and household supplies. A personal care assistant (PCA) would help him with housekeeping, shopping, carrying items, and safety.

There have been wonderful PCAs who have worked with Gary for years and some that stayed only days. He credits two PCAs with getting him stronger, walking with just a cane now. Gary did not leave the apartment the first year except for doctor's appointments. When one of those aide's dog had a litter of 4 puppies, he thought a puppy would be good company and give him a reason to get more exercise. Together, they go to the park and everyone is healthier and happier. Gary has learned to accept the assistance he needs with gait and balance issues, but he says, "I feel great!" His primary care doctor reduced his medications from 17 to 4. He bought himself a car and is now able to drive, regaining independence. He also does his own cooking. Gary's goals are to move closer to friends and family and return to the VFW/American Legion where he was involved as an auxiliary member. He is looking into finding senior housing and hopes to live in a quiet first floor apartment with his dog, not sweating the small stuff.



Photo Credit: Christine Bailey

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.