**How the Connecticut Medicaid Long-Term Care Demand Projections Produced by Mercer Human Services Consulting Relate to Connecticut’s Long-Term Services and Supports “Rebalancing” Agenda**

**July 2019**

Governor Lamont is deeply committed to ensuring that people served by Medicaid receive high quality long-term services and supports (LTSS) in the setting of their choice – be that in the community or in a nursing home. Under a Governor-led “rebalancing” plan, Connecticut has implemented a range of tools and strategies designed to enable meaningful choice. Rebalancing refers to reducing reliance on institutional care and expanding access to home and community-based services (HCBS). A rebalanced LTSS system gives Medicaid members greater choice in where they live and from whom they receive services. It also delivers LTSS that are integrated, effective, efficient, and person-centered.

To support current and future rebalancing efforts, the Department of Social Services has contracted with Mercer Human Services Consulting to update previously released projections of need for Medicaid LTSS on a town level in Connecticut. Simply put, Mercer has produced a major report that shows that Connecticut will need many fewer nursing home beds, and associated staff, and significantly more HCBS and staff, over the next twenty years. This reflects a continuing trend of consumer preference for HCBS, as well as policy interventions that Connecticut has put in place to give Medicaid members choice in where and how they receive their LTSS. The data is intended to enable policymakers, town officials, advocates and families to understand how changes in demand, as well as strategies that have been implemented by DSS, will affect how LTSS will be provided.

**What are the key messages we should take away from the Mercer report?**

* **Connecticut Medicaid initiatives** including Money Follows the Person (MFP), Community First Choice, hospital discharge planning, diversion of people from nursing homes, and pre-admission screening have, since 2011, **significantly accelerated the proportion of Medicaid-funded home and community-based services**.
* Governor Lamont proposed, and the legislature has adopted, a number of new initiatives that are anticipated to further increase use of HCBS. These include:
  + enhanced staffing for MFP;
  + funding to support development of a predictive modeling tool to support discharge of older adults to community settings, as opposed to institutional care; and
  + funding for housing vouchers.
* By incorporating all of these initiatives into modeling going forward, **Mercer expects Connecticut to increase the level of home care from the 2017 level of 67.6% to 82.3% by 2040.**
* This will mean a continued trend of less need for nursing home beds.  **The demand for nursing home beds is expected to be reduced by nearly 6,000 beds over the period from 2017 to 2040.**

**What were Mercer’s specific findings?**

* **Prior to implementation of the 2012 Connecticut LTSS rebalancing interventions, the demand in Connecticut for nursing home care was projected to increase from 17,665 Medicaid members in 2010 to 20,647 Medicaid members in 2025.**

The first ‘State of Connecticut Long-Term Demand Projections’ report was released on November 6, 2012.  The 2012 report was based on 2010 actual Medicaid data and reflected that 45% of the people receiving Medicaid LTSS were in nursing homes, while the remaining 55% were receiving HCBS in the community.  The historical trend in 2012 was based on Medicaid data from 2003 – 2010. The report projected that absent rebalancing initiatives, the state could expect a decrease in the percentage of LTSS participants receiving Medicaid nursing home services compared to those receiving HCBS – from 45% receiving nursing home care in 2010 to 42% in 2025. While the projection documented a 3% reduction based on preference of LTSS participants for care in the community, the total number of people served in the nursing home over the same period was estimated to increase from 17,665 to 20,647 due to growth in the overall older adult population.

* **The actual shift in demand from nursing home care to home and community-based services is consistent with Mercer’s original 2012 forecast as well as the 2014 forecast, giving confidence in the accuracy of the projection methodology.**

In addition to projecting future demand based on historical trends, the 2012 and 2014 reports incorporated the anticipated impact of the Department’s rebalancing initiatives (e.g., Money Follows the Person) to predict future utilization. The projected trends, which included changes in town level state population by gender and age group, indicated a significant reduction in future demand for nursing home care. In fact, the 2012 report projected a decrease from 17,665 Medicaid participants in nursing homes in 2010 to 11,824 in 2025, despite the growth in the population over the age of 65. The 2012 projection of 11,824 participants in nursing homes by 2025 was further reduced to 11,651 in the 2014 report. The 2019 report includes actual data through 2017, and is consistent with the expected decrease in demand for nursing home care that was projected in both the 2012 and 2014 reports. In 2017, 14,908 Medicaid participants received services in nursing homes, a decrease of 2,757 people from 2010.

* **Mercer’s new forecast projects a continued decrease in demand for nursing home care through 2040.**

Mercer’s 2019 report includes projections through 2040. These new projections are based on actual data through 2017 and take into account Governor Lamont’s new rebalancing initiatives. The 2019 projection through 2040 reflects continued decrease in demand for nursing home care from 14,908 Medicaid participants in 2017 to 8,913 Medicaid participants in 2040. This decrease is primarily attributed to an increase in consumer awareness of HCBS and continued Medicaid investments in those services.

**What process did Mercer use to make its projections?**

Data analytics and modeling in the report are based on primary source data including: 1) Connecticut town-level population projections by age and gender [CT State Data Center at the Map and Geographic Information Center; 2) state Labor Market Area data [nine Connecticut areas, Connecticut Department of Labor]; 3) state nursing facility cost reports [for cost year 2017, DSS]; 4) nursing home 15-mile radius data [based on last available census report by provider, DSS]; 5) Connecticut Medicaid claims data [Medicaid Management Information System vendor DXC]; and 6) zip code to town crosswalk [CT Economic Resource Center]. Population projections are based on statistical models that utilize historical birth, mortality and migration data to inform modeling. The overarching process for developing the projections involved these process steps:

* Projecting the population of the state by age and gender;
* Projecting the proportion of the state population that is Medicaid eligible under HUSKY C, which serves those who are age 65 or over, blind or with a disability;
* Projecting the proportion of those eligible for HUSKY C that meet nursing facility level of care (NFLOC); and
* Projecting the proportion of the NFLOC group using HCBS.

The process to predict future demand for LTSS was conducted at the Labor Market Area level, with projections based on the individual towns in the labor markets, which were then aggregated at the statewide level. Incidence of Medicaid-eligible older adults and people with disabilities, as well as the number of these people who will be at nursing facility level of care, was assumed at a town level. In 2012, the projected impact of LTSS initiatives on future trends was based on DSS’ assumptions related to impact. With two years of actual data available in 2014, trends were extrapolated with the assumption that the level of success demonstrated from 2012 to 2014 would continue. Based on the anticipated success of Governor Lamont’s new LTSS rebalancing initiatives, projections for the period of 2019 through 2040 continue the assumptions reflected in the historical trend.

**What is Medicaid’s role with LTSS?**

Medicaid is the predominant funder of these services in both Connecticut and across the country. Historically, most people who needed LTSS received those services in nursing homes, but both use of, and Medicaid spending on, care in the community has increased significantly over the last ten years. This process is known as “rebalancing.”

* **In SFY 2018, 64% of Medicaid members who required LTSS received services in the community.** This equates to a monthly average of 29,585 Medicaid members served in the community while the balance of 36% –a monthly average of 16,685 – received care in an institution.
* **This percentage has increased significantly over time.** Since SFY 2003, the percentage of Medicaid clients receiving care in the community has increased by 39% -- from 46% in SFY 2003 to 64% in SFY 2018.

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| **PERCENTAGE OF CONNECTICUT MEDICAID LONG-TERM CARE (LTC) CLIENTS OVER TIME** | | | |
| **SFY** | **Home & Community Care** | **Institutional**  **Care** | **Total Monthly Average LTC Medicaid Clients** |
| 2003 | 46% | 54% | 37,969 |
| 2018 | 64% | 36% | 46,270 |

* **In SFY 2018, 53% of Medicaid expenditures for LTSS were for services in the community.** This represents a 6.0% increase from SFY 2017 in the percentage of Medicaid long-term care expenditures for individuals in the community versus an institution.
* **This percentage has increased significantly over time.** Since SFY 2003, the percentage of Medicaid long-term care expenditures for community care has increased by 71% – from 31% in SFY 2003 to 53% in SFY 2018.

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| **PERCENTAGE OF CONNECTICUT MEDICAID EXPENDITURES FOR LONG-TERM CARE  OVER TIME** | | | | | |
| **SFY** | **Home & Community Care** | **Institutional Care** | **Total LTC Medicaid Expenditures** | **Total Medicaid Expenditures** | **Percentage of Total Medicaid Expenditures for LTC** |
| 2003 | 31% | 69% | $1,914,273,731 | $3,406,301,048 | 56% |
| 2018 | 53% | 47% | $3,259,286,335 | $7,740,843,361 | 42% |

**How did Connecticut make these shifts?**

Connecticut’s rebalancing approach includes the following strategies:

* **Money Follows the Person.** Through June 2018, MFP has been the main driver behind the transition of over 5,700 individuals from nursing facilities to the community using a “housing plus supports” approach that braids Medicaid HCBS with housing vouchers. MFP is also implementing strategies including housing development, workforce development, service and systems gap analysis and hospital discharge planning interventions.
* **Universal assessment and allocation methodology.** Using federal Balancing Incentive Program (BIP) funds, Connecticut developed and implemented a universal assessment with the intent of using it across all LTSS populations. The assessment tool is linked to an algorithm which uses clinical data to develop level of need groupings. Use of the universal assessment is being rolled out incrementally across CFC and the waivers.
* **MyPlaceCT.** An additional accomplishment of the BIP was the establishment of a web-based platform called “MyPlaceCT”. Coordinated with 2-1-1, MyPlaceCT increases access to comprehensive information regarding LTSS. See [www.myplacect.org](http://www.myplacect.org/).
* **Community First Choice.** Launched in July 2015, CFC enables Medicaid members who require nursing facility or other institutional level of care to self-direct community-based services, including personal care attendants under individual budgets, with the support of a fiscal intermediary.
* **Nursing home diversification.** Another important historical feature of rebalancing was $40 million in grant and bond funds through SFY 2017 dedicated to nursing facilities that were interested in diversifying their scope to include home and community-based services.
* **Waiver services.** Connecticut has approved 1915(c) home and community-based services waivers that enable services to older adults, individuals with physical disabilities, individuals with behavioral health conditions, children with complex medical profiles, individuals with intellectual disabilities, children with autism spectrum disorder and individuals with acquired brain injury.
* **Preadmission screening.** DSS utilizes a web-based system for the federally mandated Preadmission Screening and Resident Review (PASRR) program.  The system identifies persons who are in need of both long-term and short-term institutional care, and recommends alternatives to those whose preference is for home and community-based services options.

Connecticut rebalancing work continues to evolve and expand over time. The following new supports for rebalancing, which were proposed by Governor Lamont, were included in the enacted budget for the biennium (Public Act 19-117):

* funding of $726,400 in FY 20 and FY 21 in DSS to support seven positions to increase the agency's capacity to process MFP applications within a tighter timeframe;
* funding of $800,000 in FY 20 and $500,000 in FY 21 in DSS to assist with developing a predictive modeling tool to identify older adults who are discharged from hospitals to nursing homes and who are, without intervention, at high risk for a long-term stay; and
* funding of $239,100 in the Department of Housing for rental assistance to support this effort.