Connecticut Department of Social Services

Making a Difference

Modernization of Connecticut Medicaid Nursing Facility Reimbursement: An Essential Component of Long-Term Services and Supports "Rebalancing"

Forum for the Committees of Cognizance

February 6, 2020

Agenda

1. Key Definitions and Strategic Points
2. Data on Medicaid Long-Term Services and Supports
3. Review of Rebalancing Tools
4. Overview of Medicaid Reimbursement Principles
5. Review of Current Method for Setting Nursing Home Rates
6. Overview of Transition to Acuity-Based “Case Mix” method

Key Definitions and Strategic Points

Key Definitions and Strategic Points

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 the Governor's strategic "rebalancing" plan, Connecticut has implemented a range of tools and strategies designed to support these aims.

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.*

- Connecticut, and all states, have been responding to major shifts in consumer demand by "rebalancing" spending on LTSS – in 2019 in Connecticut, 52% of Medicaid LTSS spend was on HCBS and 48% was on institutional care

- Recent Connecticut town-level data projects that by 2040:
  - there will be a **major increase in demand for and use of home care provided through Medicaid**, **from 67.6% of long-term care enrollees in 2017 to 82.3% by 2040**
  - there will be a concomitant **drop in demand for nursing home care**, with a **reduction in demand of nearly 6,000 beds**

Connecticut has implemented diverse rebalancing strategies under its multi-million dollar federal Money Follows the Person grant and through state funding, including:

- supporting over 27,000 people on Medicaid HCBS "waivers"
- working with the UConn Center on Aging to track and trend diverse data points* and develop responsive interventions
- testing services and supports, such as supportive housing
- examining and making recommendations for workforce needs
- promoting consumer education
- transitioning almost 6,000 individuals from institutional settings to the community with Medicaid services and housing assistance

* https://health.uconn.edu/aging/wp-content/uploads/sites/102/2019/11/2019-Q3-MFP-report.pdf

That said, compared with leading states, Connecticut continues to:

- have a high incidence of people served in nursing homes, and beds per 1,000 people
- have a low rate of people transitioning to the community from nursing home stays
- have the highest rate of admission to the hospital from home health care in the country

Sources: detail included in Appendix A

Further:

- Connecticut currently has 3,000 more licensed nursing home beds than are presently needed
- Connecticut's nursing home occupancy rate, as of 9/30/19, was **88%**
- Connecticut's benchmark occupancy rate, for efficient and effective operations as required under the Medicaid State Plan, is **90%**

As consumer demand continues to shift from nursing home care to care at home, DSS remains committed to supporting long- term care facilities in evolving their business models. DSS:

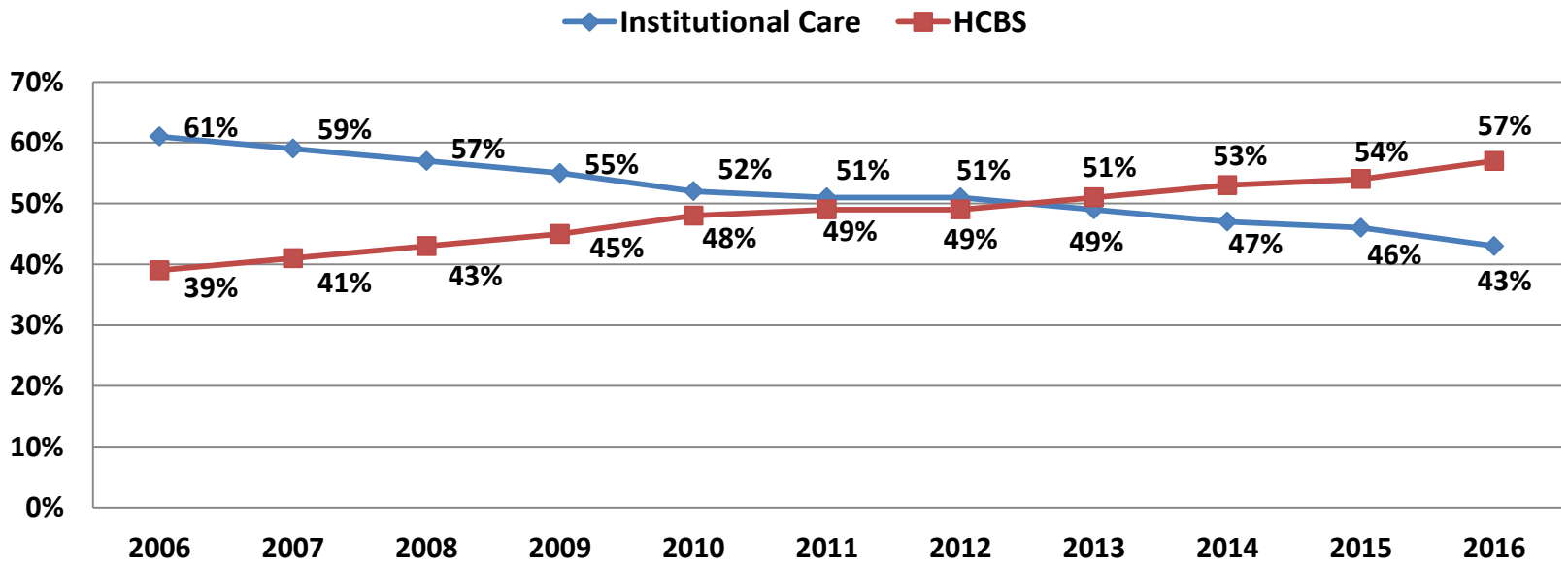
- recognizes the relationship between reimbursement and the quality of care and positive care experience that residents need and deserve
- is following the lead of approximately 30 other state Medicaid programs that have already transitioned their means of paying nursing homes to case mix reimbursement

- recognizes the need to:
  - provide incentives for nursing homes to admit people with high acuity and complex needs
  - structure reimbursement to promote provision of direct care
  - enhance quality of care through value-based purchasing
- will continue to use a range of tools, including the Certificate of Need process, to align the number of licensed beds with current and future needs of Connecticut residents

Data on Medicaid Long-Term Services and Supports

National LTSS Spending Trends

In FY 2016, Medicaid programs overall spent approximately $94 billion on home and community-based services (HCBS) compared to $72 billion on institutional care. The increasing proportion of spend on HCBS has been driven by concerns about the **high cost of institutional care** and **beneficiary preferences to live in the community**.



Source: Medicaid and CHIP Payment and Access Commission (MACPAC)

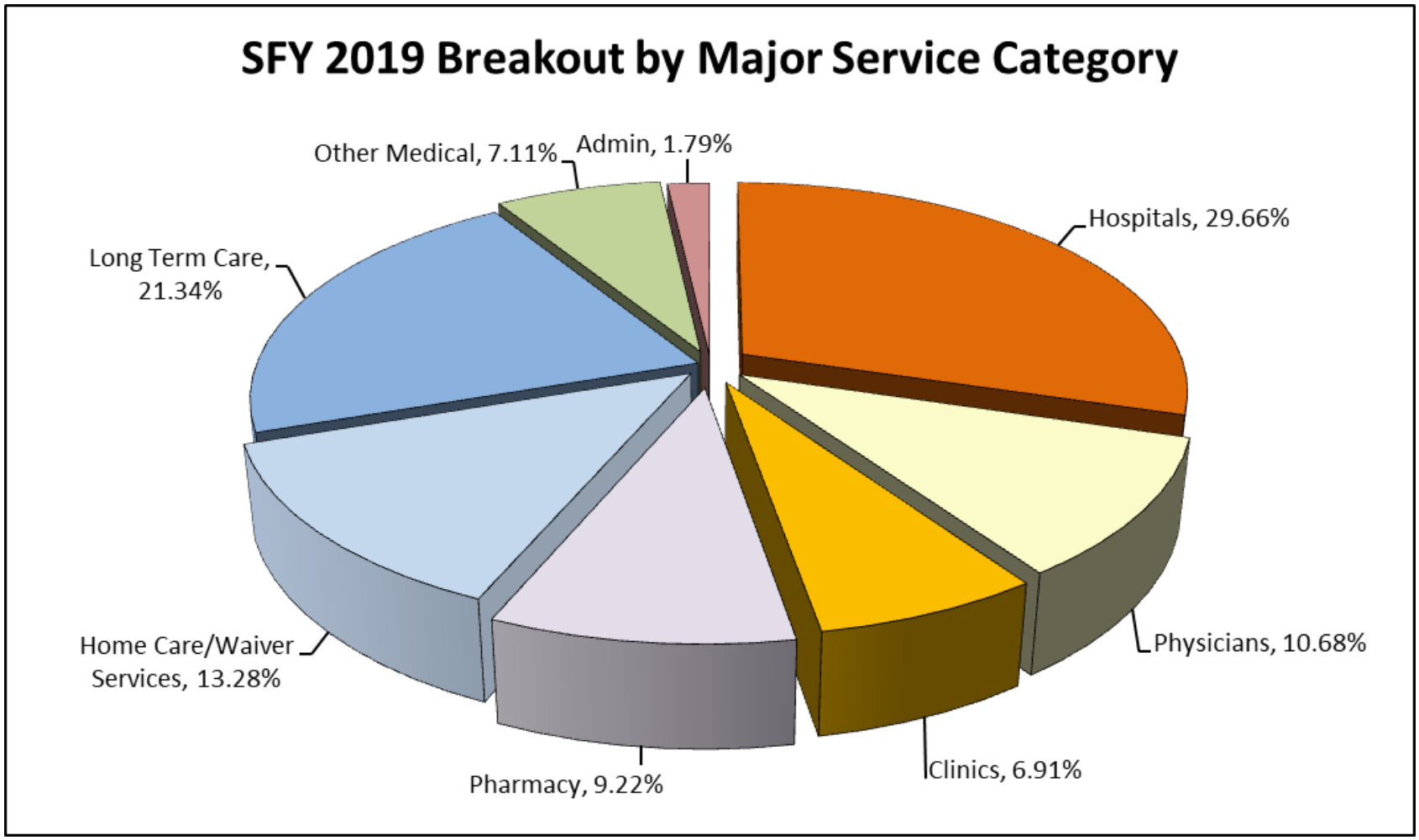
State LTSS Spending Trends

The Office of Policy & Management Long-Term Care Planning Committee SFY 2019 Annual Report* states that:

- In 2019, Connecticut Medicaid spent $3.2 billion on long-term care (LTC), reflecting 41% of overall Medicaid expenditures of $7.9 billion
- 52% was spent on HCBS and 48% was spent on institutional care
- A total of 46,194 HUSKY Health members received LTSS in 2019, 64% of whom received Medicaid LTSS in the community, and 36% of whom received institutional care

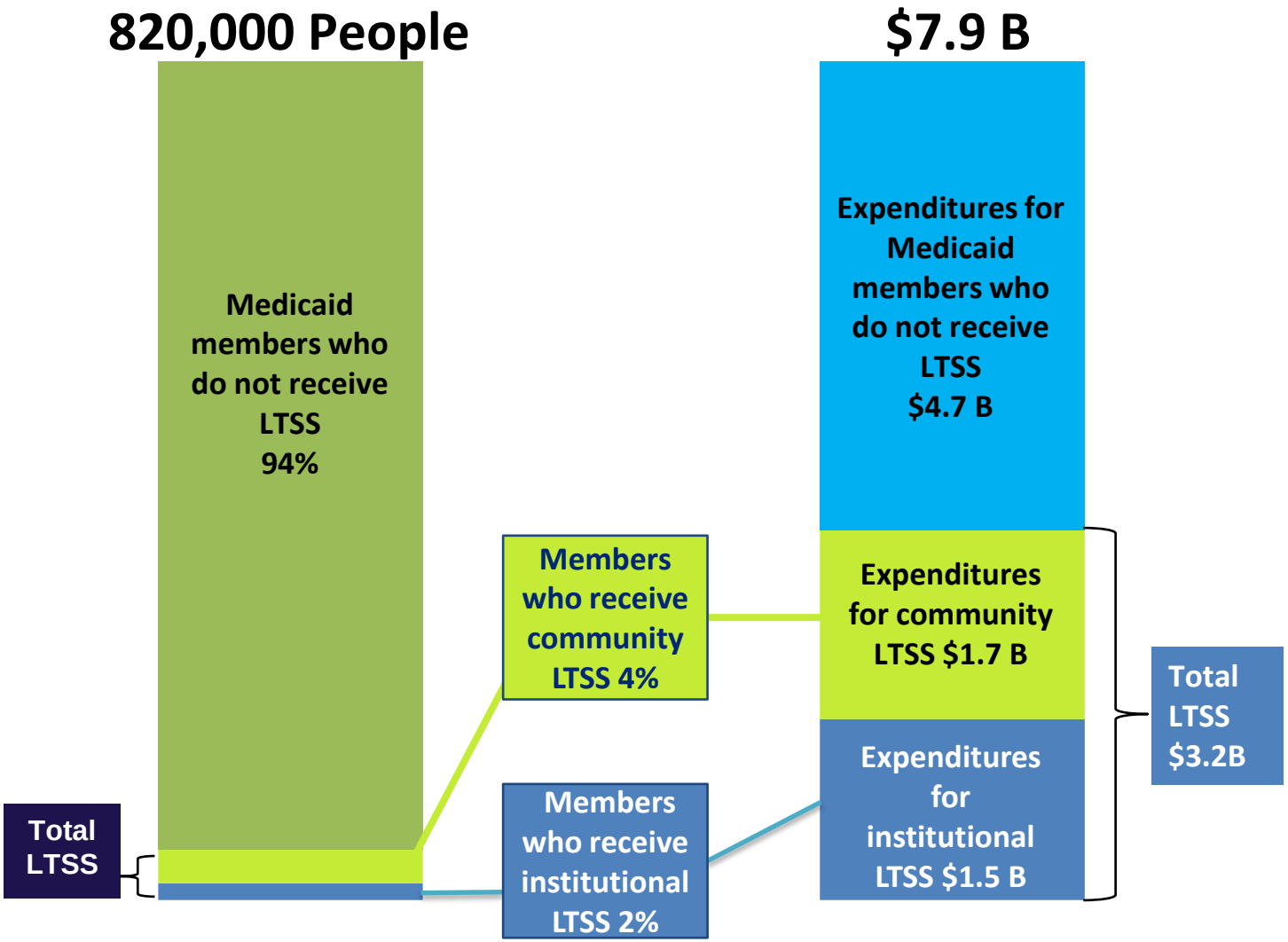
* https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/Long-Term-Care-Planning-Committee-Report---January-2020.pdf?la=en

Major Service Categories



Long-Term Care refers to institutional LTSS, including nursing home services
Home Care/Waiver refers to home and community-based LTSS
Note that the above spending does not include DDS or DMHAS Medicaid services

Significant Spend on Small Population



Source: 2019 Connecticut CMS-64 Report

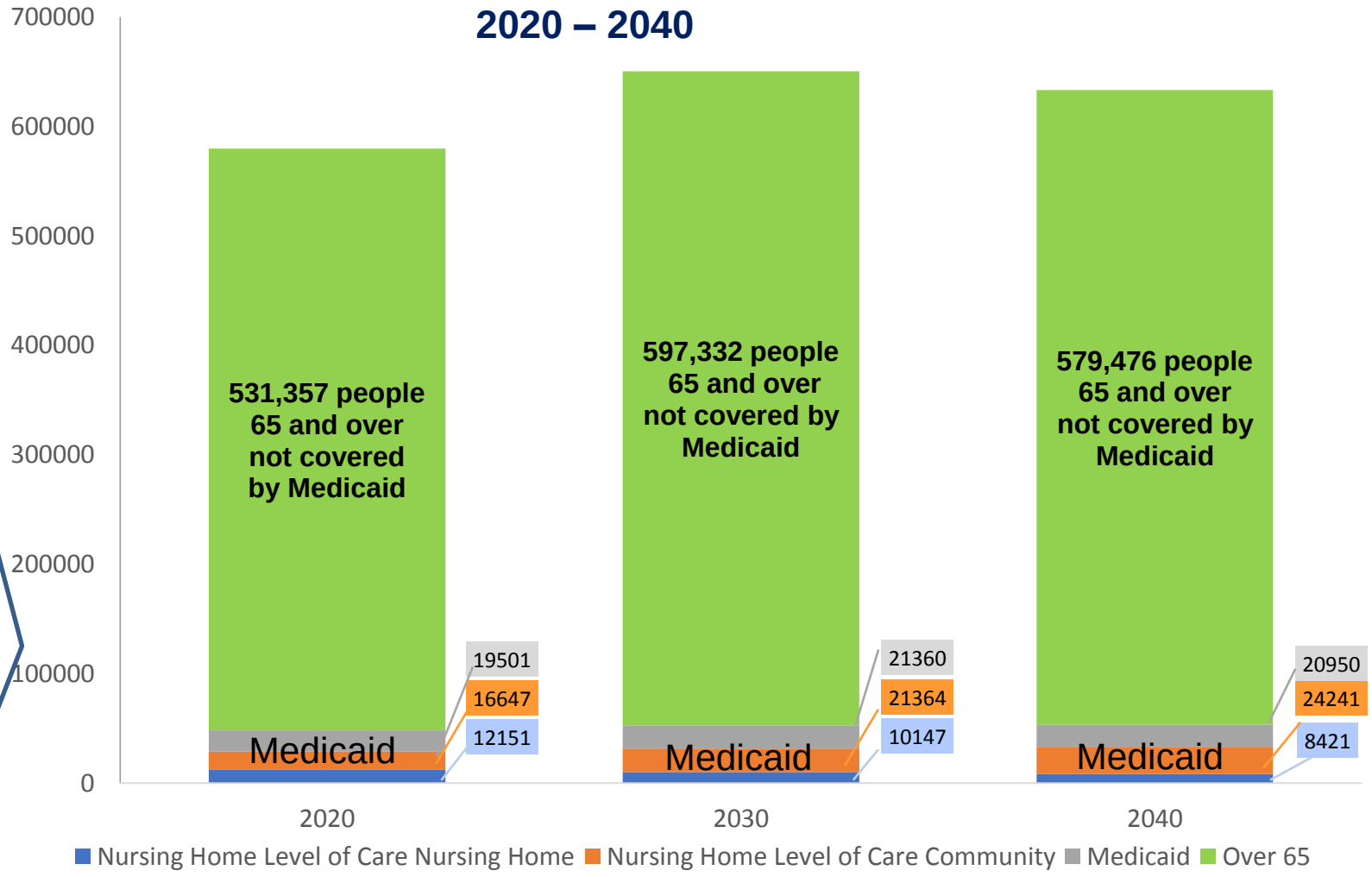
Expected Population Trends

Expect a 10% (2,713) increase in people at Medicaid nursing home level of care through 2030.

If all are served in the **community:** we will see a projected increase of **$95,145,700**

If all are served in **nursing homes:** we will see a projected increase of **$209,962,885**

Expected trends in Connecticut Population Age 65 and Over 2020 – 2040



Source: Connecticut State Data Center, UCONN July 2019
CMS 372: average annual HCBS cost/person = $35,070; average annual nursing home cost/person = $77,391

Connecticut Nursing Home Data

2018 – 2019	
Total Nursing Facility Beds on 9/30/19	**25,352**
Average Occupancy Rate on 9/30/19	**88%**
Number of Occupied Beds on 9/30/19	**22,197**
Percentage of Occupied Nursing Facility Beds funded by Medicaid in SFY 2019	**70%**
Average Monthly Number of non-Medicaid Residents in a Nursing Facility in SFY 2019	**6,688**

Source: OPM Long-Term Care Planning Committee SFY 2019 Annual Report https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/Long-Term-Care-Planning-Committee-Report---January-2020.pdf?la=en

Incidence of Nursing Facility Beds

Connecticut has a high incidence of nursing home residents per 1,000 population (6th in the country) and beds per 1,000 population (11th in the country). Compared to other New England states, CT has the second highest number of Medicaid enrollees age 65+ residing in in nursing facilities. CT also has the second highest rate of nursing home beds per 1,000 in New England.

New England States	Number of Nursing Homes	Nursing Home Residents	Nursing Home Beds
Rhode Island	12.09	7.78	8.55
Connecticut	**15.67**	**6.56**	**7.71**
Massachusetts	16.47	5.96	7.02
New Hampshire	17.29	5.09	5.78
Maine	12.87	4.67	5.24
Vermont	19.36	3.78	4.61
Per 1,000 population			

Source: Kaiser Family Foundation, 2017 https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/

Rebalancing Tools

Overview of Tools

- Governor-led Strategic Rebalancing Plan, including goals around system change, workforce, consumer education and transition of individuals from institutional settings to the community
- Town level data on current and projected need for LTSS
- Moratorium on new nursing home beds
- Benchmark for nursing home occupancy rate
- Certificate of Need (CON) process
- Removal of stop-loss provisions

Rebalancing Plan

We are guided by a **comprehensive, Governor-led, legislature-supported rebalancing plan** with these key goals:

- ***Improve effectiveness and efficiency of*** *Connecticut's* ***HCBS system***
- ***Decrease hospital discharges to nursing facilities*** *among those requiring care after discharge*
- ***Transition 8,000 people from nursing homes to the community*** *by 2020 – through 2019, 5956 people transitioned*
- ***Build capacity in the community workforce*** *sufficient to sustain rebalancing goals*
- ***Increase availability of accessible housing*** *and transportation*
- ***Adjust supply of institutional beds*** *and community services and supports* ***based on demand projections***

Connecticut's plan 'Strategic Rebalancing Plan: A Plan to Rebalance Long-Term Services and Supports 2020 is found at the following link: https://portal.ct.gov/dss/Health-And-Home-Care/Medicaid-Long-Term-Care-Demand-Projections/Medicaid-Long-Term-Care-Demand-Projections

Town Level Data

- DSS has partnered with Mercer Government Consulting to produce a report titled *State of Connecticut Medicaid Long-Term Care Demand Projections,** which uses data to predictively model long-term care trends for each of the 169 towns and cities in Connecticut over the next 20 years

- This report refreshes previously released analyses that tracked very closely to actual experience

* https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Medicaid-Long-Term-Care-Demand-Projections/Town-by-Town-appendices-CT-LTC-Demand-Report-Appendices.pdf?la=en

Town Level Data (Cont.)

- In brief, the Mercer report released on July 22, 2019, projects a **major increase in demand for and use of home care provided through Medicaid**, **from 67.6% of long-term care enrollees in 2017 to 82.3% by 2040**

- Over the same period, the report projects a concomitant **drop in demand for nursing home care**, with a **reduction in demand of nearly 6,000 beds**; the state currently has over 3,000 excess licensed nursing home beds

Moratorium

- In 1991, the legislature enacted a two-year moratorium on new nursing facility beds, with limited exceptions [P.A. 91-8]
- This moratorium was extended six times and in 2015 was indefinitely extended [P.A. 15-5]
- P.A. 15-5 also requires bed relocations and closures to be consistent with the strategic rebalancing plan, provided that:
  - the availability of beds in the area of need is not adversely affected; and
  - there is no increase in expenditures to the state

Benchmark for Occupancy

- Occupancy rates are an important means of ensuring full use of nursing home beds while protecting states from reimbursing for costs that are not related to patient care

- **Occupancy Rate** is defined as:

  Total resident days / (number of beds x 365 days)

Benchmark for Occupancy (cont.)

- To align with rebalancing efforts, and in recognition of its excess number of licensed beds over current and projected need, Connecticut has elected to use a **minimum occupancy rate of 90%**

- Nationally, the optimal occupancy rate is typically described as being 95% and the CMS-approved minimum occupancy rate is currently 90%

- Connecticut's occupancy rate, as of 9/30/19, was **88%**

Benchmark for Occupancy (cont.)

- Title 2 CFR 200.466 specifically requires Medicaid programs to remove costs related to idle capacity or "empty space"

- If idle capacity costs, which are not directly related to patient care, are not removed, the result is an artificial inflation of per-bed operation costs and less money spent on patient care

Avoidance of Increased Costs

When nursing homes reduce the number of beds for which they are licensed, but do not remove idle capacity from the system, the result is increased cost to the Medicaid program. To avoid this result, facilities must:

- delicense beds; and
- reduce fixed costs proportional to the number of beds that are being delicensed; and/or
- repurpose beds for unmet or underserved specialized needs; and/or
- close facilities

Removal of Stop-Loss Protections

- PA 19-117 authorized rebasing of nursing home rates to reflect actual costs if a facility's occupancy was less than 70% or the facility had three consecutive periods of low Medicare star quality ratings

- When rebasing was done, no nursing home demonstrated three consecutive periods of low star ratings

- However, DSS did identify homes at less than 70% occupancy

Removal of Stop-Loss Protections

- Effective July 1, 2019 DSS:
  - removed the "stop-loss" provision for homes with occupancy below 70%; and
  - implemented a 2% increase in nursing home rates for enhancing staff wages and benefits (the first of three phased-in increases over the biennium)
- As a result, of the 213 total nursing homes in Connecticut: **204** homes experienced **a net increase in reimbursement** and **9** homes* experienced **a net decrease in reimbursement, prior to interim rate agreements with DSS**

* Quinnipiac Valley Center (Wallingford), Arden House (Hamden), Hewitt Health & Rehabilitation Center (Shelton), Kimberly Hall South Center (Windsor), Wolcott Hall Nursing Center (Torrington), Meridian Manor Corporation (Waterbury), Village Green of Bristol Rehab & Health Center (Bristol), Governor's House (Simsbury), and Carolton Chronic and Convalescent Center (Fairfield).

Interim Rate Agreements

DSS received interim rate requests from Apple, Genesis and Meridian Manor covering eight of the nine homes that received rate reductions. DSS has entered into interim rate agreements with seven of the homes, resulting in restoration of rates retroactive to July 1, 2019, contingent on:

- a total reduction of 503 licensed beds;
- closure of a home (not one of the nine); and
- agreements to work with DSS on repurposing beds for high need uses, including, but not limited to, ventilator/hemodialysis and neuro rehab

Certificate of Need (CON)

The Department of Social Services (DSS) is responsible for the **Certificate of Need (CON)** process for nursing homes. CONs are a state regulatory tool that is used to prevent excess supply and expenditures, and to promote quality of services.

DSS accepts and reviews CON applications for providers that wish to:

- introduce a new function or new service
- terminate a service or substantially decrease total bed capacity
- relocate all or a portion of a facility's licensed beds to a new facility or replacement facility to meet a priority need
- incur capital expenditures exceeding either $2.0 m. or exceeding $1.0 m. with an increase in facility square footage
- under a moratorium exception, add beds restricted to use by residents with AIDS or traumatic brain injuries

Certificate of Need (CON)(Cont.)

In reviewing CON requests, the Commissioner may consider:

- whether there is a demonstrated bed need in the towns within a 15-mile radius in which the request will be located;
- area specific utilization and reductions in utilization rates to account for the increased use of less institutional alternatives;
- Medicaid State Plan and all applicable state regulations and statutes;
- the financial feasibility of the request and impact to the applicants rate and overall financial wellbeing;
- impact on quality, accessibility, and cost-effectiveness of health care delivery in the region;
- potential changes to the applicant's current utilization statistics, the business interests of all owners, partners, associates, stockholders and operators, and personal background of such persons; and
- any other factor that the Department deems relevant

Medicaid Reimbursement Principles

Medicaid Reimbursement Principle

Reasonable cost is a basic Medicaid reimbursement principle that guides states in the development of rate-setting methods. The goal is to reimburse the *allowable cost of providing services to residents*.

Reasonable cost reimbursement methods help states to:

- control cost
- maintain quality
- allow for patient access to care
- support state and federal policy goals

Medicaid reimbursement methodologies must also adhere to federal regulations that limit reimbursement for "idle capacity" or unused space. States are required *not* to pay for services that are unrelated to patient care. (Title 2 CFR 200.466)

Current Method for Setting Nursing Home Rates

Current Rate Setting

To set Medicaid nursing home rates:

- the DSS Commissioner is authorized to use nursing facility cost reports to determine Medicaid rates [C.G.S. 17b-340]

- Facilities are required to file cost reports annually and to report all incurred costs

- DSS conducts a review of the cost reports to determine which costs are allowable and which are unallowable

Current Rate Setting (cont.)

- Section 1903(a)(7) of the federal Social Security Act requires Medicaid reimbursement to be "economic and efficient" and in accordance with patient care

- Medicaid may only reimburse for allowable costs, which are determined in accordance with the Medicaid State Plan, as well as state and federal regulations

Current Rate Setting (Cont.)

Allowable Costs:

- **Direct** - Nursing and nurse aide personnel salaries, related fringe benefits and nursing pool costs.
- **Indirect** - Recreation, social worker, dietary, housekeeping, laundry, and supplies related to patient care.
- **Administrative and General** - Maintenance and plant operation expenses, salaries and related fringe benefits for administrative and maintenance personnel.
- **Property (Fair Rent)** - In lieu of depreciation and interest costs, fair rent is paid for real property and non-moveable equipment costs. The historical cost of a property asset is paid over its useful life and given a rate of return (ROR). ROR is linked to the Medicare borrowing rate (2.766%). Under state statute the maximum ROR is 11%.
- **Capital Related** - Property taxes, insurance expenses, moveable equipment leases and depreciation.

Unallowable Costs:

- Disallowed salaries and fees and those over reasonable cost caps
- Disallowed Managerial Administrative Compensation over reasonable cost caps
- Disallowed Rent
- Building Interest, Depreciation, Amortization
- Physical Therapy, Speech Therapy, and Occupational Therapy Expenses (paid by Medicare)
- Miscellaneous desk review disallowances not related to patient care (advertising, bad debt etc.)

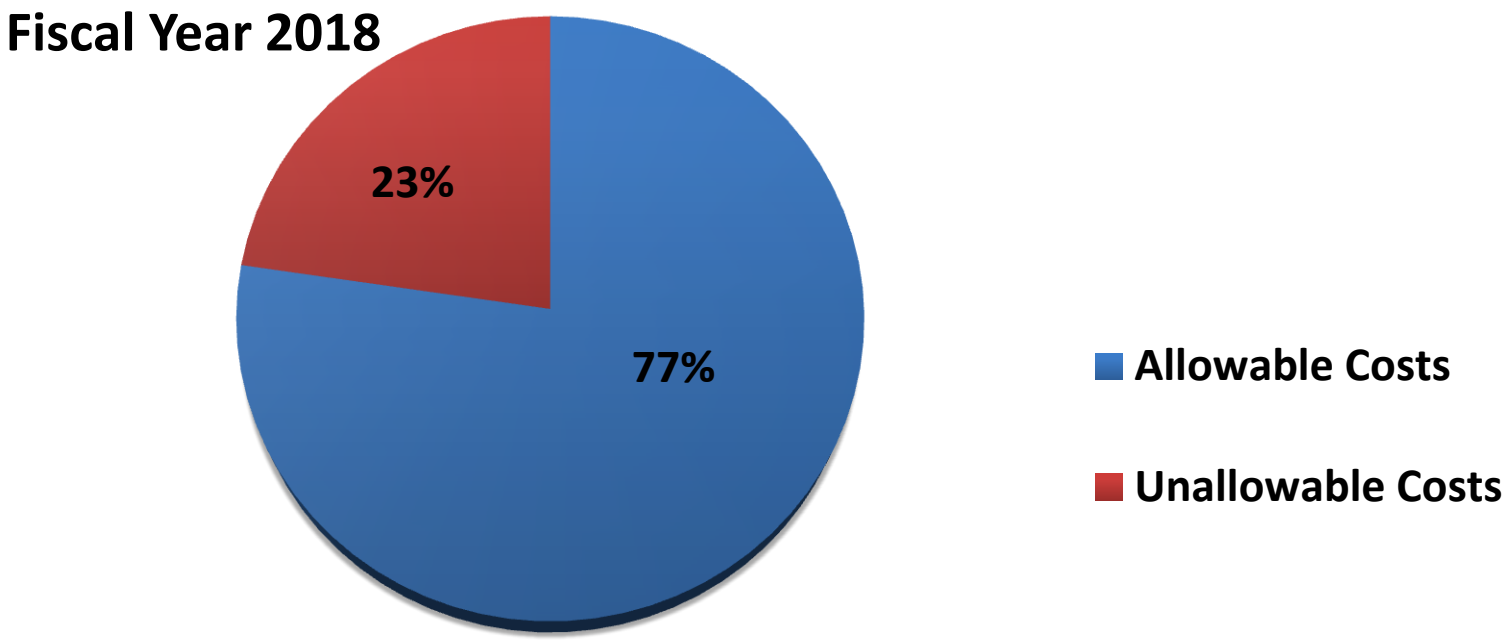
Current Rate Setting (Cont.)

Section 2102.3 of CMS Publication 15-1-21 provides guidance on both direct and indirect costs. These are considered reasonable and allowable if the "costs for individuals covered by the program are not borne by others not so covered and the costs for individuals not so covered are not borne by the program."

Guidance further states "Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity." Related, Connecticut uses **average provider costs** to determine if a cost is reasonable, necessary, proper and generally accepted within the nursing facility industry.

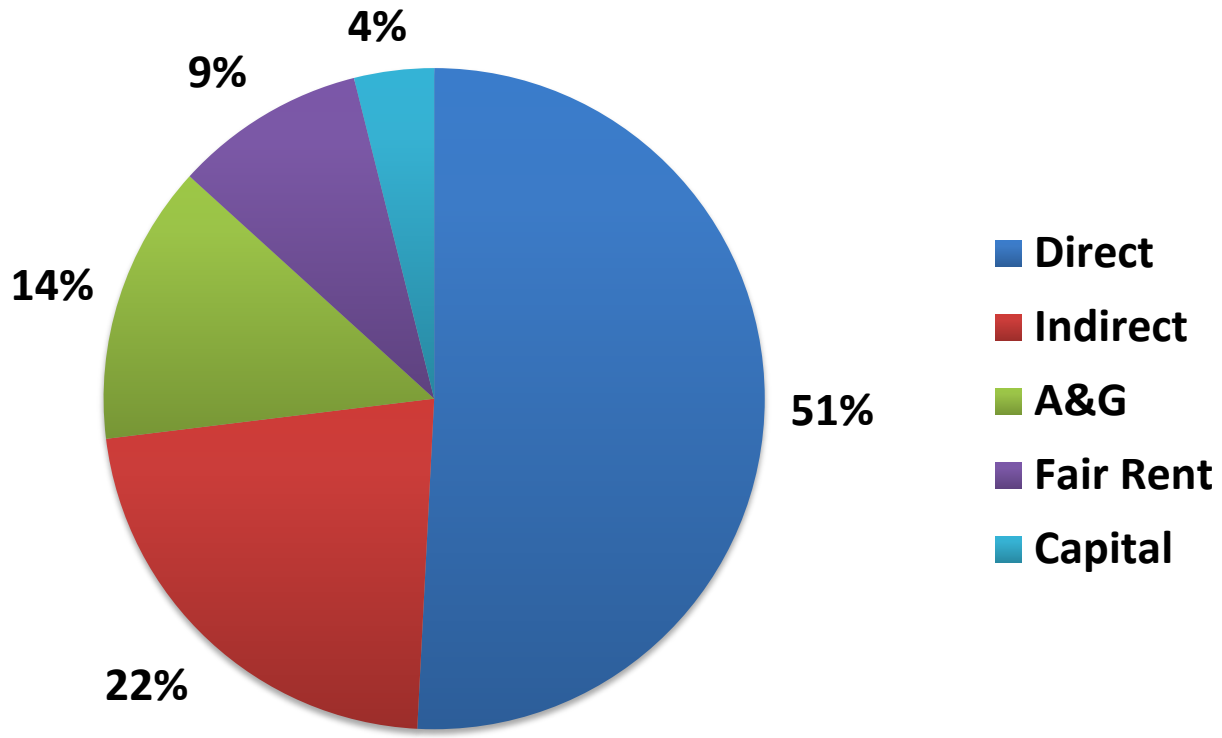
Current Rate Setting (Cont.)

Typically, 20% - 25% of reported nursing facility costs are not Medicaid reimbursable, based on state and federal regulations. In FY 2018, 23% of costs included on Connecticut nursing facility cost reports were unallowable.



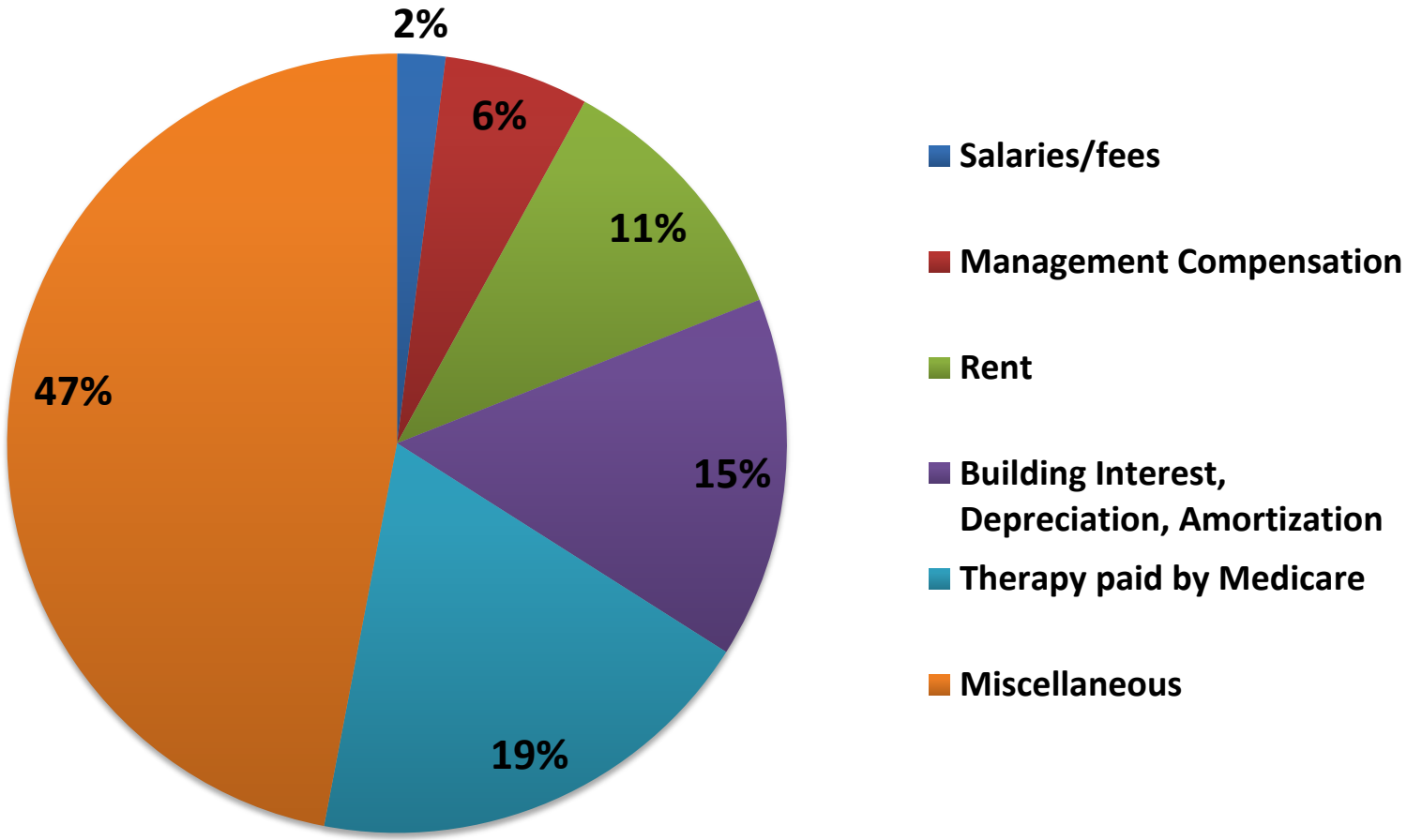
Current Rate Setting (Cont.)

According to the 2018 cost reports, **51%** of allowable costs went towards direct resident care. The chart below shows the distribution of **allowable costs**. A&G refers to Administrative & General costs.



Current Rate Setting (Cont.)

The chart below shows the distribution of **unallowable costs**, which reflect costs above the average provider costs that are set as caps .



Transition to Acuity-Based "Case-Mix" Method


MYERS AND
STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Nursing Facility Payment Modernization

DSS is transitioning Medicaid nursing facility direct care reimbursement from cost-based methodology to a case mix payment system. Implementation of the new methodology will be ongoing and phased-in as DSS works with stakeholders on model design. Stakeholders are invited to visit the DSS webpage for information regarding case mix reimbursement, meeting notifications, and additional information.

An acuity-based reimbursement method will aid DSS in its goals of:

- supporting a meaningful continuum of LTSS
- modernizing Medicaid reimbursement
- aligning payment with the acuity of residents
- preparing providers for value-based payment approaches

NURSING FACILITY PAYMENT MODERNIZATION

Initiative Objectives

- To reflect the Department's overall interest and work in modernizing rates.
- To further the Department's longstanding LTSS rebalancing agenda, which utilizes diverse strategies to ensure that Medicaid members have meaningful choice in the means and setting in which they receive LTSS.
- To establish a framework to align with value-based payment in the future.
- To develop a reimbursement methodology that supports budget neutrality.

NURSING FACILITY PAYMENT MODERNIZATION

Guiding Principles

- Align reimbursement with the anticipated resource needs of each provider based on the acuity of their specific residents.
- Provide incentive for nursing homes to admit and provide care to persons in need of comparatively greater care.
- Implement periodic adjustments to reimbursement rates to account for changes in the acuity mix of each provider's residents.
- Encourage sufficient provider spending on direct care resources.

PROJECT PHASES

Three Phase Implementation

Phase 1:

- RUG-IV Based Case Mix Transition
- Value-Based Purchasing (VBP) Quality Measures (QMs)

Phase 2:

- Minimum Data Set (MDS) Verification Review Program. MDS is the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes.
- Evaluation of the Capital and Fair Rental Value (FRV) components
- VBP Evaluation and Enhancements

Phase 3:

- Transition to Patient Driven Payment Model (PDPM)
- Capital and FRV Component Modernization
- VBP Evaluation and Enhancements

CURRENT RATE SYSTEM

Reimbursement Methodology

Cost-Based Reimbursement System

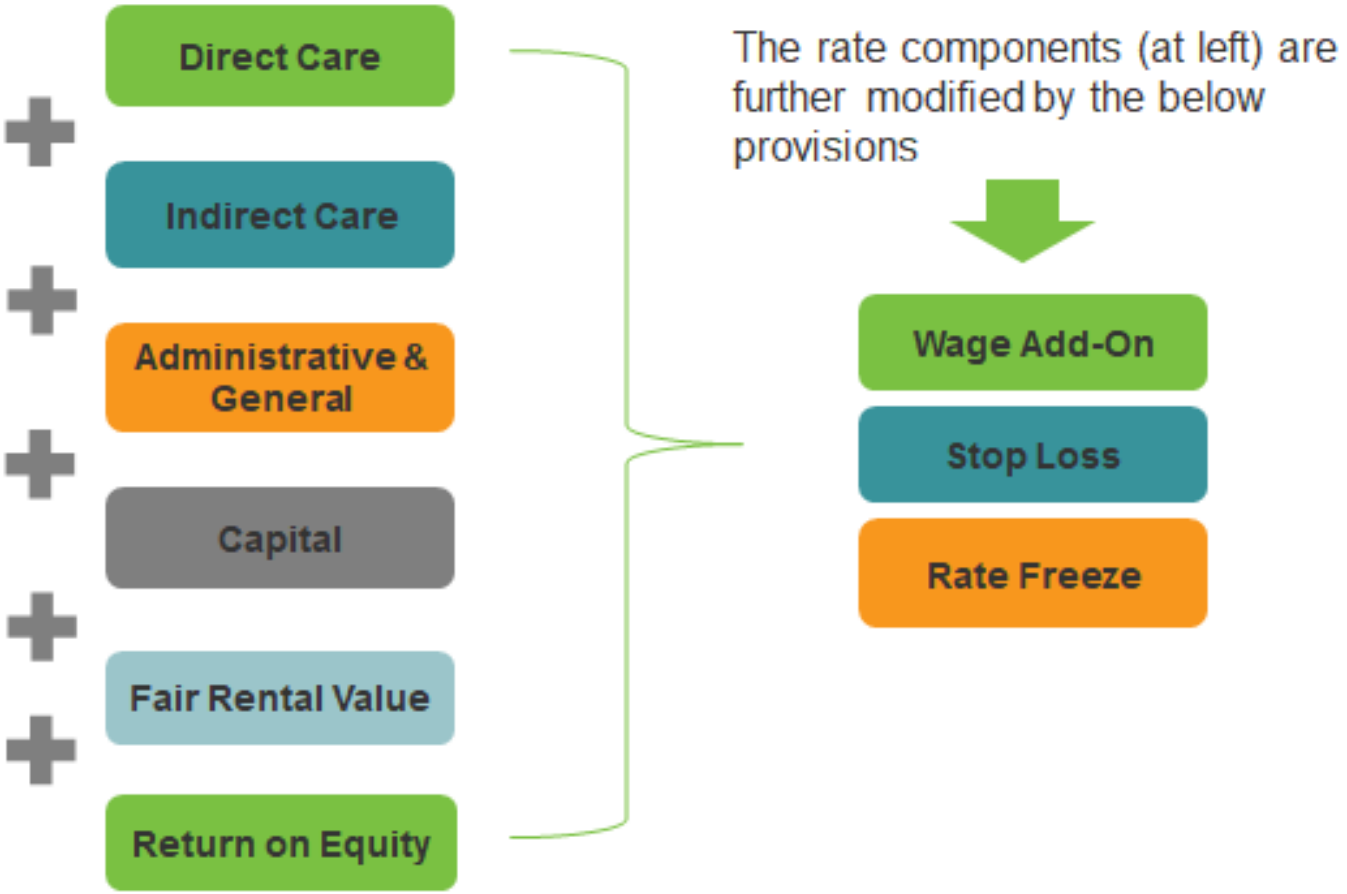
- Allowable total cost / resident days
- Per diem cost does not vary by payer source
- Per diem is subject to a ceiling/limit

Other Provisions

- Portions of the rate have been frozen over time
- Stop-loss provisions
- Wage add-on

CURRENT RATE METHODOLOGY

Rate Calculation



CASE MIX SYSTEM

Reimbursement Methodology

What is Case Mix?

- "Case" refers to residents.
- "Mix" refers to the differences among those residents.
- "Case Mix" is the overall differences within a group of residents and compares individual cases relative to one another within the mix. It is a means to identify acuity differences among residents within a population.

What is Case Mix Index?

- Case Mix Index (CMI) is a weight or numerical acuity score that reflects the relative predicted resources necessary to provide care to a resident.
- The higher the case mix index weight, the greater the resource requirements for the resident (i.e., a more acute resident).
- For example, residents falling into a RUG category with a CMI of 2.00 take twice the nursing resources as a resident assessed in a RUG category with a CMI of 1.00.

CASE MIX SYSTEM

Reimbursement Methodology

Where does information to calculate Case Mix Index come from?

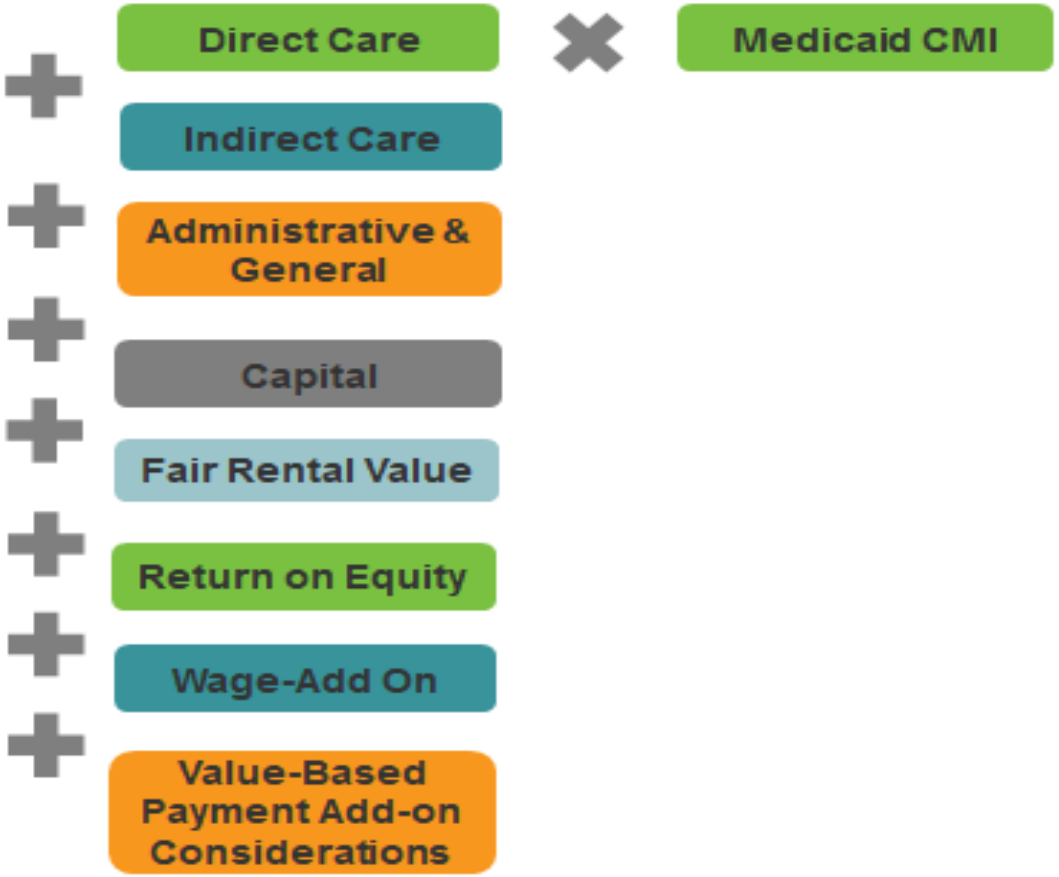
- All Medicare and/or Medicaid certified facilities must complete periodic status and care planning assessments of each resident within their facility (regardless of payer).
- The MDS resident assessment instrument is utilized for these periodic assessments.
- The completed MDS assessments are utilized to calculate the Case Mix Index.

Why Case Mix?

- Case Mix can be used as a method for allocating cost to residents based on each resident's nursing care needs.
- Reimbursement based on Medicaid resident allowable cost.
- Periodically adjusts reimbursement based on the Medicaid resident mix of each facility.
- Encourages nursing facilities to accept high need residents.
- Aligns with rebalancing efforts by incentivizing care for high need residents and creating less incentive for accepting low need residents in the nursing facility setting.

CASE MIX METHODOLOGY

Rate Calculation



RATE METHODOLOGY COMPARISON

Methodology Incentive Matrix

Methodology Incentives	Current System	Case Mix System
1. Cost-Based Reimbursement System	X	X
2. Per Day Calculations Based on Cost for Medicaid Residents Only		X
3. Periodic Rate Adjustments to Update for Changes in Medicaid Resident Mix		X
4. Encourages Access for High Needs Residents		X
5. Aligns with State Rebalancing Efforts		X

OTHER PAYMENT CONSIDERATIONS

Phase-in Considerations

- Consideration will be given to phasing in the new payment rates.
- Phase-in options will be assessed during the modeling process.

Other Considerations

- Evaluation of rate-setting methodology for special populations.
- Incorporating Value-Based Purchasing (VBP) concepts into reimbursement.
- Development of a reimbursement methodology that supports budget neutrality.

PROVIDER LEARNING AND ENGAGEMENT

Available Resources

Stakeholder Meetings

- Updates prior to implementation will be provided.

Live Training and Webinars

- A combination of in-person training, live and recorded webinars will be utilized to educate providers on the transition to a case mix reimbursement system.

Case Mix Index Report User Guide

- A CMI report user guide will be developed to provide guidance on regulatory requirements, report elements, report details, and resources available for assistance.

PROVIDER LEARNING AND ENGAGEMENT

Available Resources

Web Portal

- Preliminary and final resident rosters will be posted to a web portal hosted by Myers and Stauffer. IP addresses will be collected from users identified for each facility so providers can access their rosters once posted. This process helps to securely transmit protected health information.

Myers and Stauffer Help Desk and Staff Assistance

- Myers and Stauffer maintains a help desk to assist with case mix rosters, and also has staff available during business hours to answer rate-setting questions as needed.

DSS Website Dedicated to Nursing Home Reimbursement

- The DSS website will be utilized to post updated information, resource documents, training documents, presentations, and other pertinent provider communications. The website can be found using the following link: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Home-Reimbursement-Modernization-to-Acuity-Based-Methodology

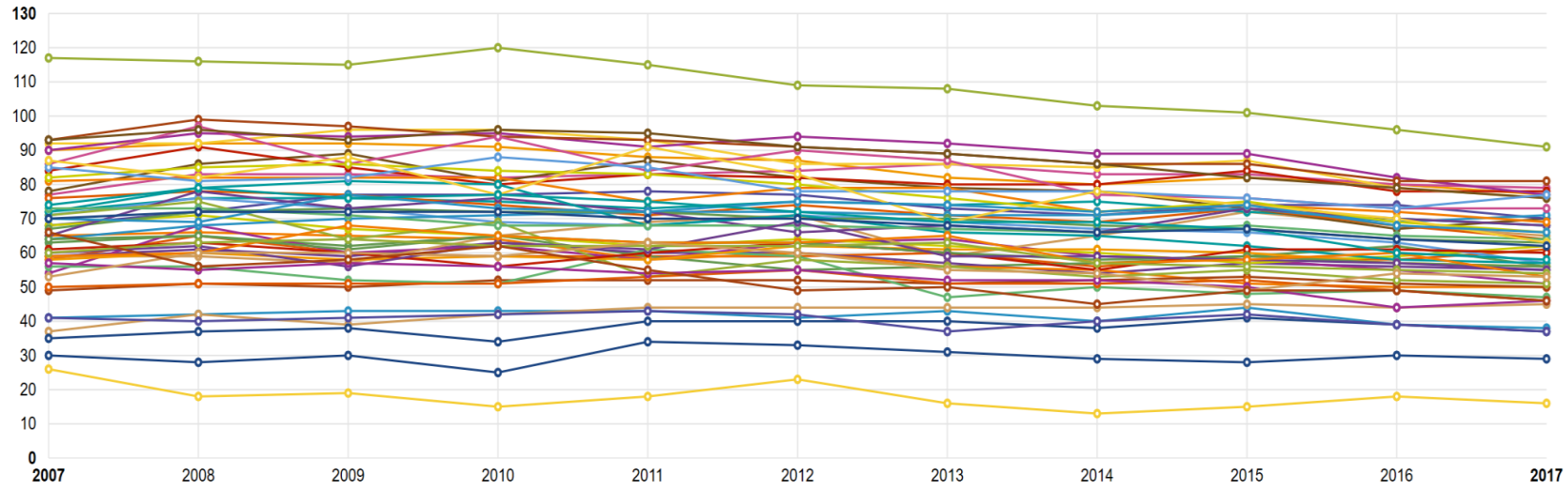
Questions?

Appendix A
Cross State Comparisons of Utilization

CT Has Highest Rate of Medicare Stays

Medicare Service Use: Skilled Nursing Facilities | The Henry J. Kaiser Family Foundation

Timeframe: 2007 - 2017

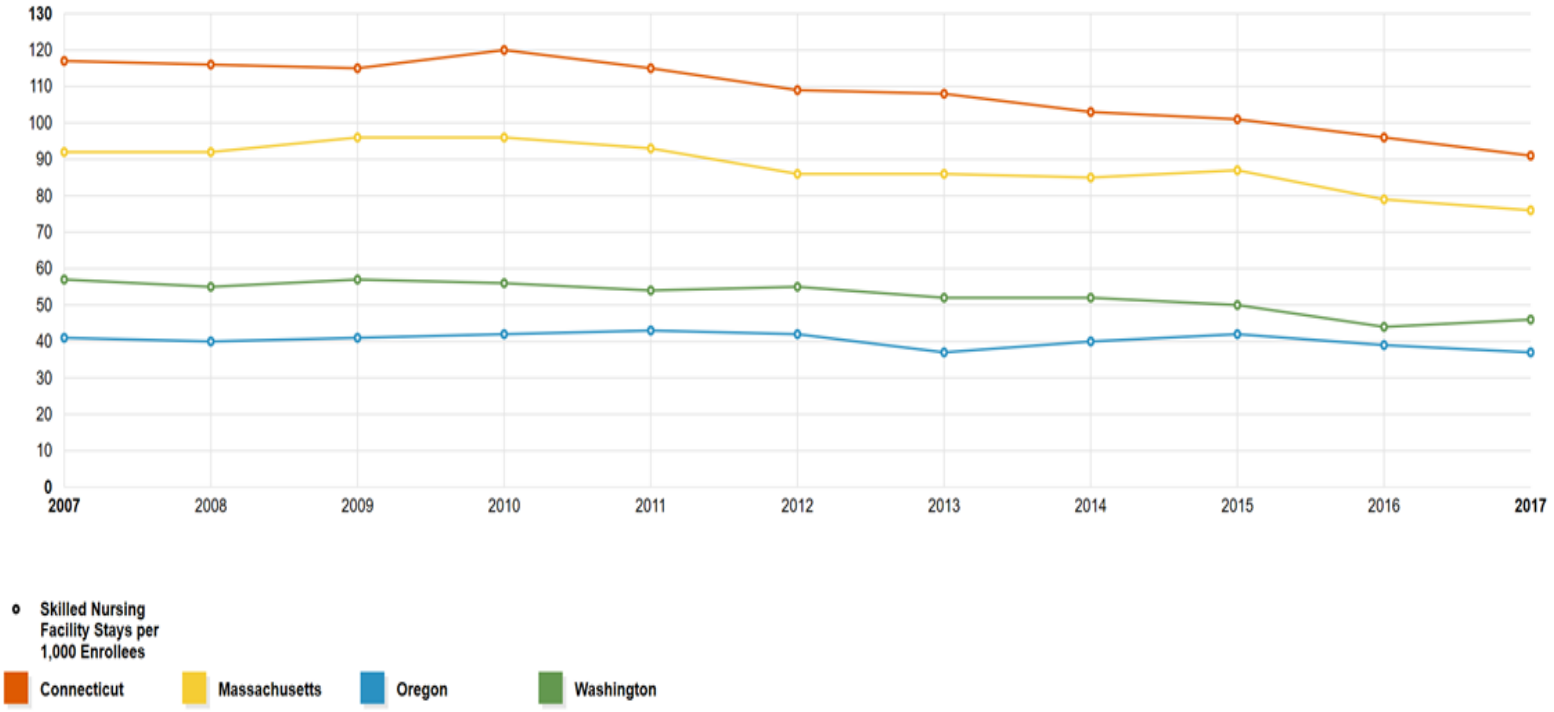


Notes
Analysis excludes beneficiaries in Medicare Advantage and beneficiaries with zero months of Medicare Part A coverage.
Data are as of July 1 of the year indicated in each timeframe.
Sources
Kaiser Family Foundation analysis of a five percent sample of Medicare claims from the CMS Chronic Condition Data Warehouse, 2000-2016. Kaiser Family Foundation analysis of a twenty percent sample of Medicare claims from the CMS Chronic Condition Data Warehouse, 2017.

CT Has Much Higher Rate Than Leaders

Medicare Service Use: Skilled Nursing Facilities | The Henry J. Kaiser Family Foundation

Timeframe: 2007 - 2017



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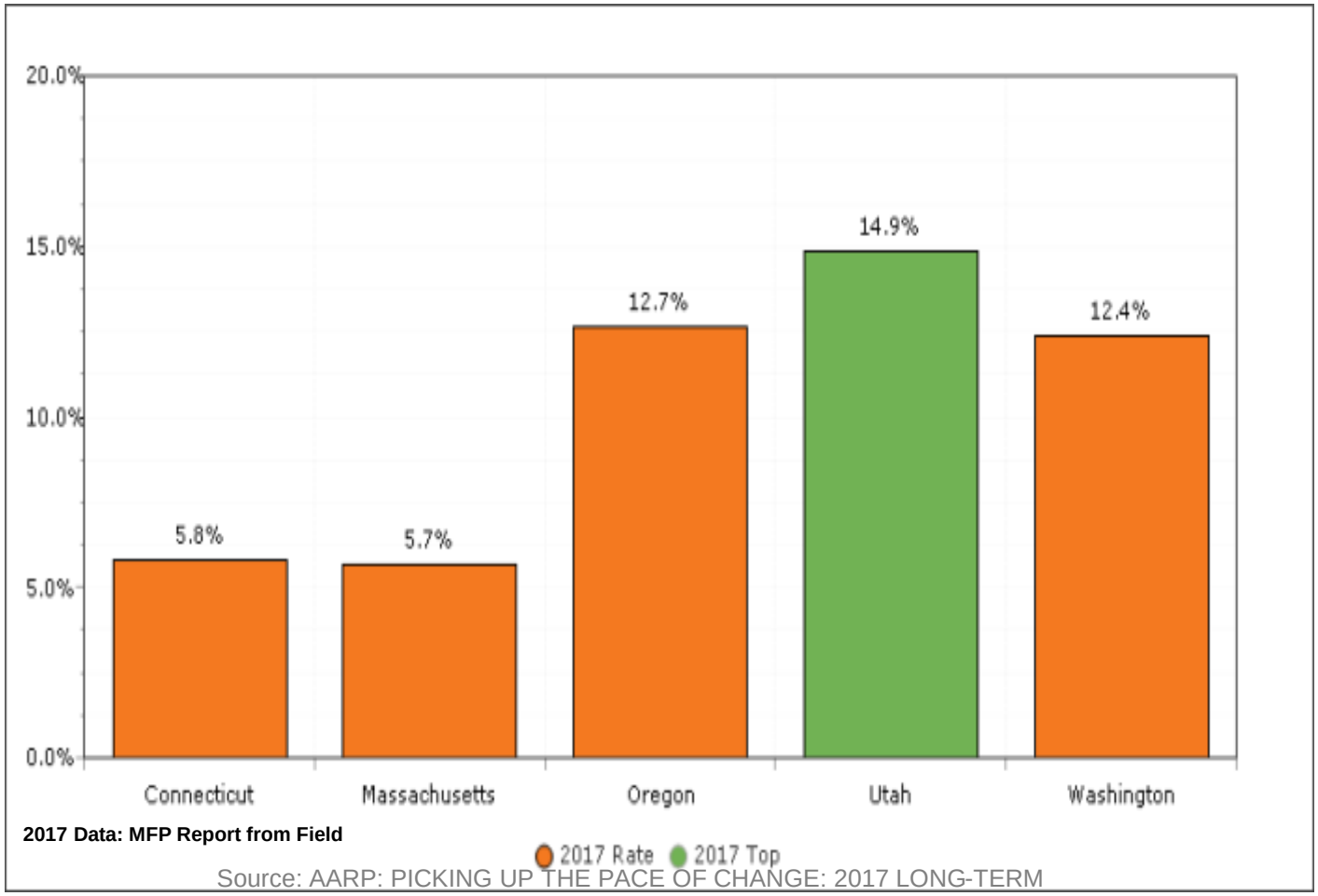
Transitions Back to Community

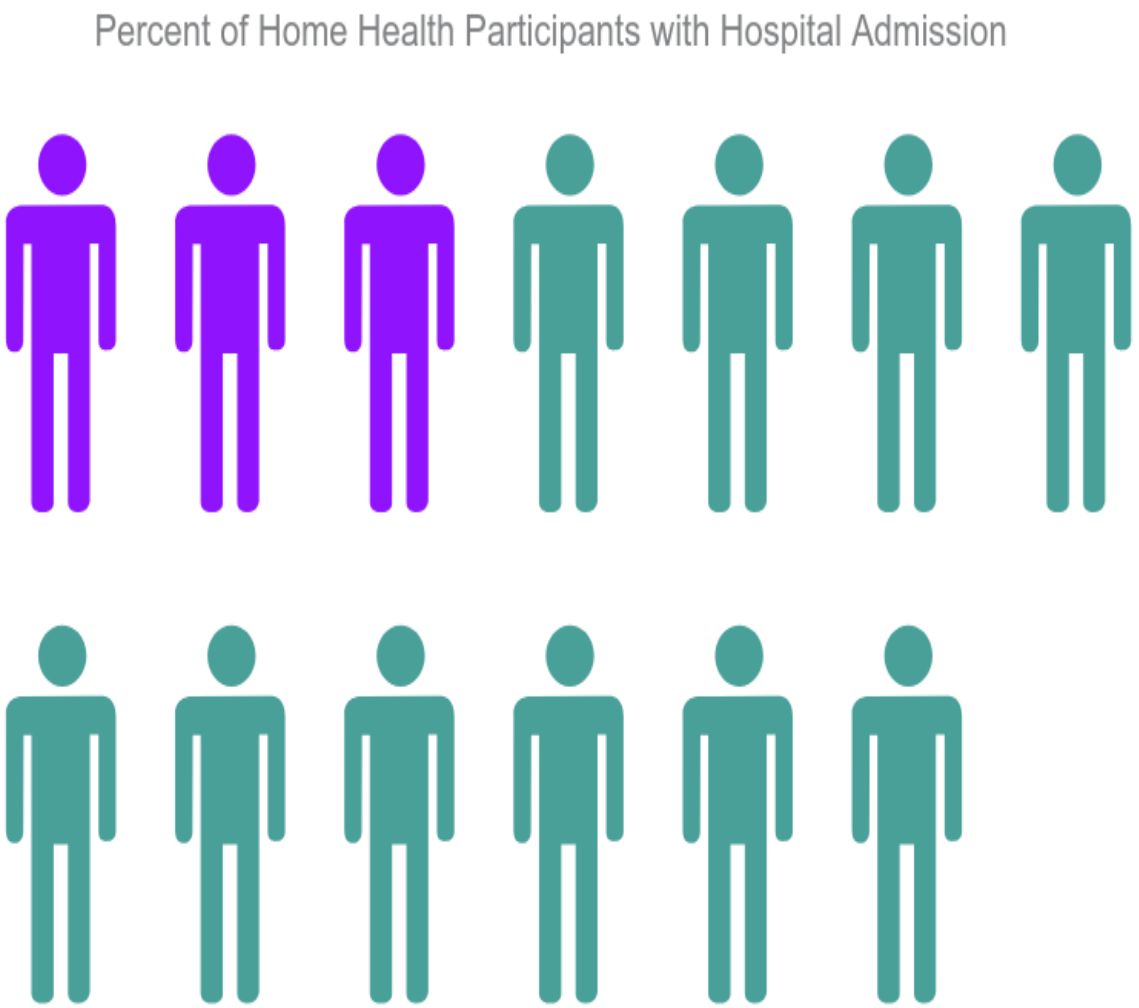
Connecticut also has a comparatively low percentage of people with 90+ day nursing home stays successfully transitioning back to the community



Source: AARP: PICKING UP THE PACE OF CHANGE: 2017 LONG-TERM SERVICES AND SUPPORTS

Highest Rate of Hospital Admission from Home Health

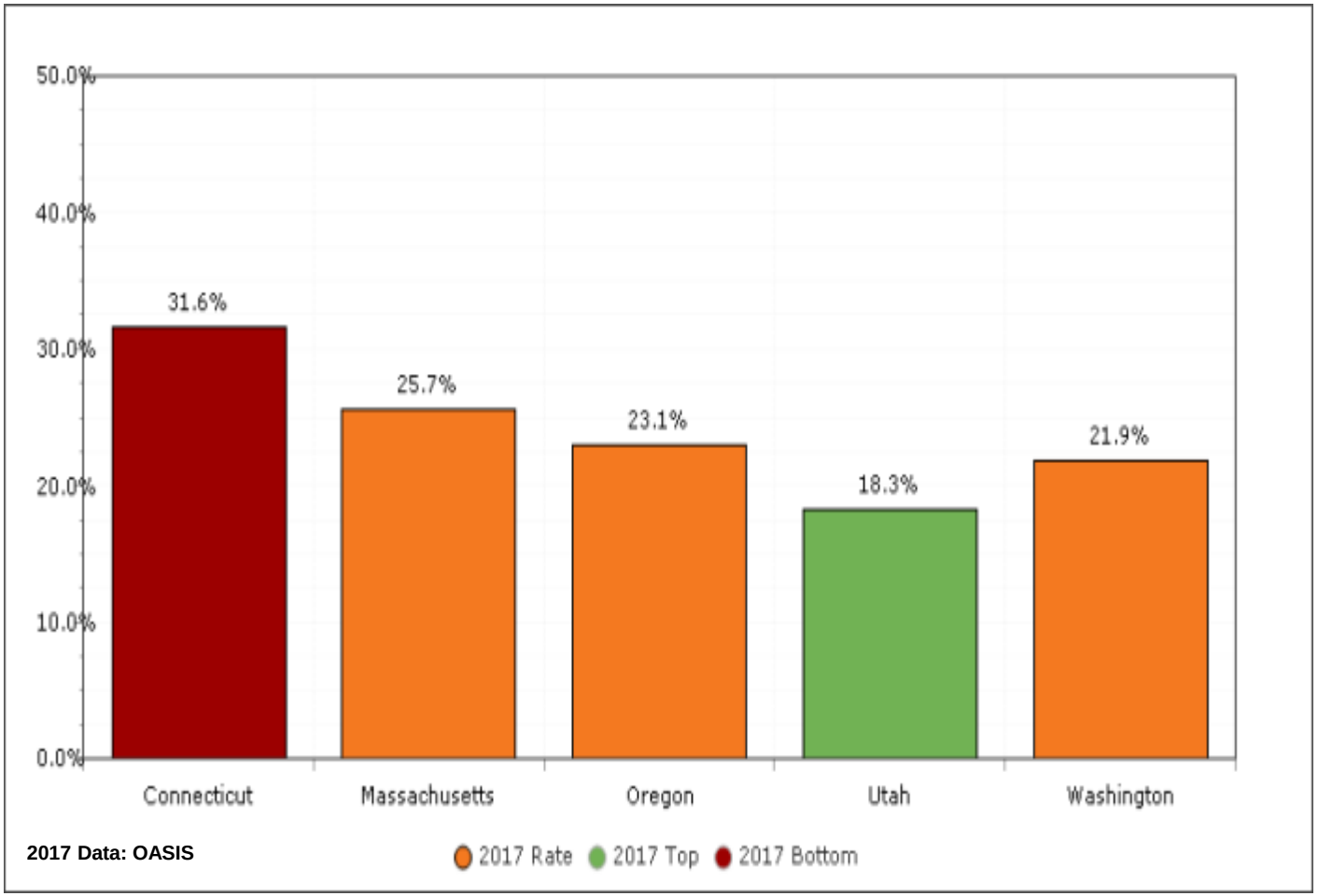
3 out of 10 people who use home health care are discharged to the hospital - this is the highest rate in the United States



Source: AARP: PICKING UP THE PACE OF CHANGE: 2017 LONG-TERM SERVICES AND SUPPORTS 2017

CT Has Much Higher Rate Than Leaders

Percent of home health patients with a hospital admission



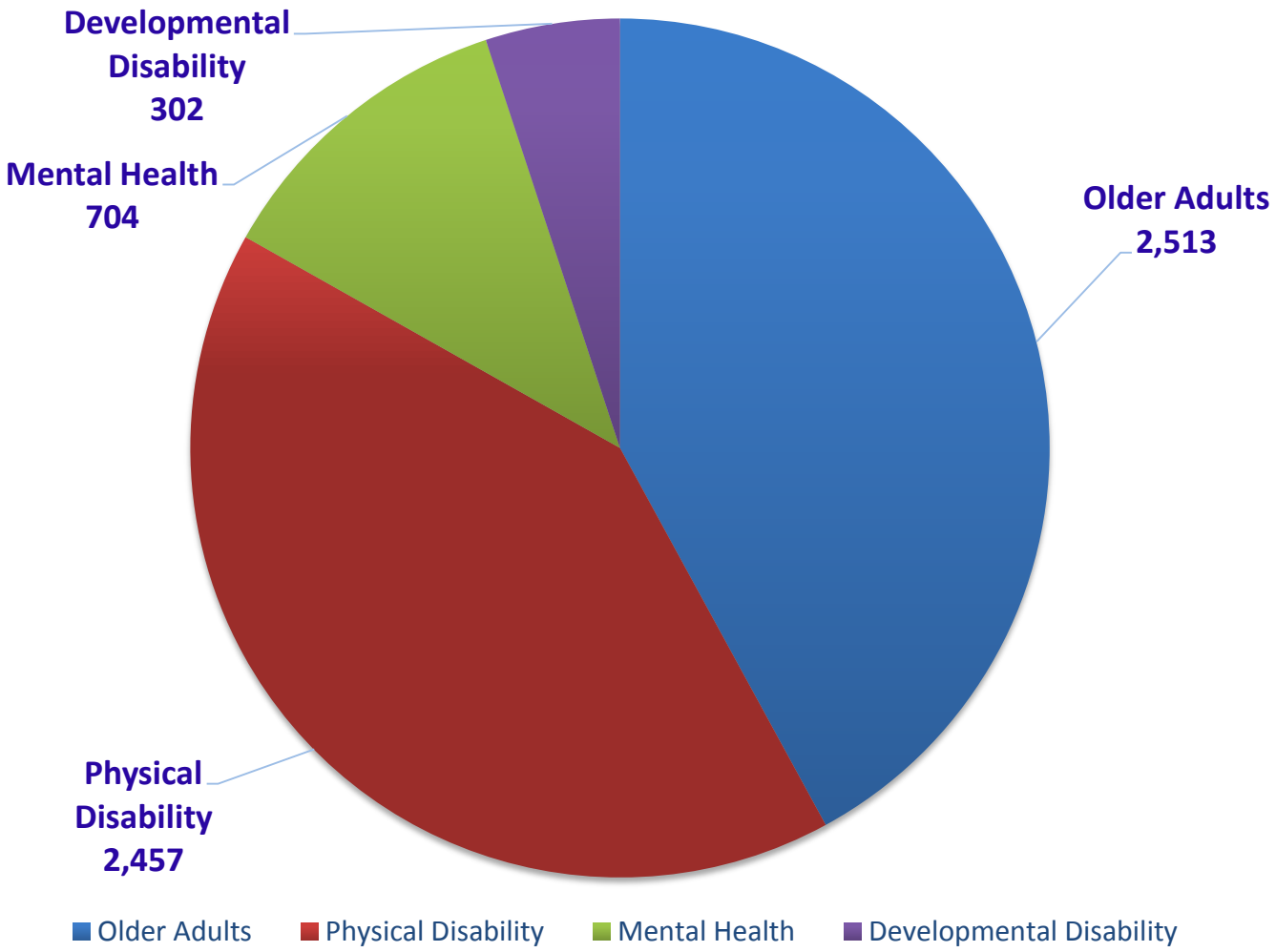
Source: AARP: PICKING UP THE PACE OF CHANGE: 2017 LONG-TERM SERVICES AND SUPPORTS

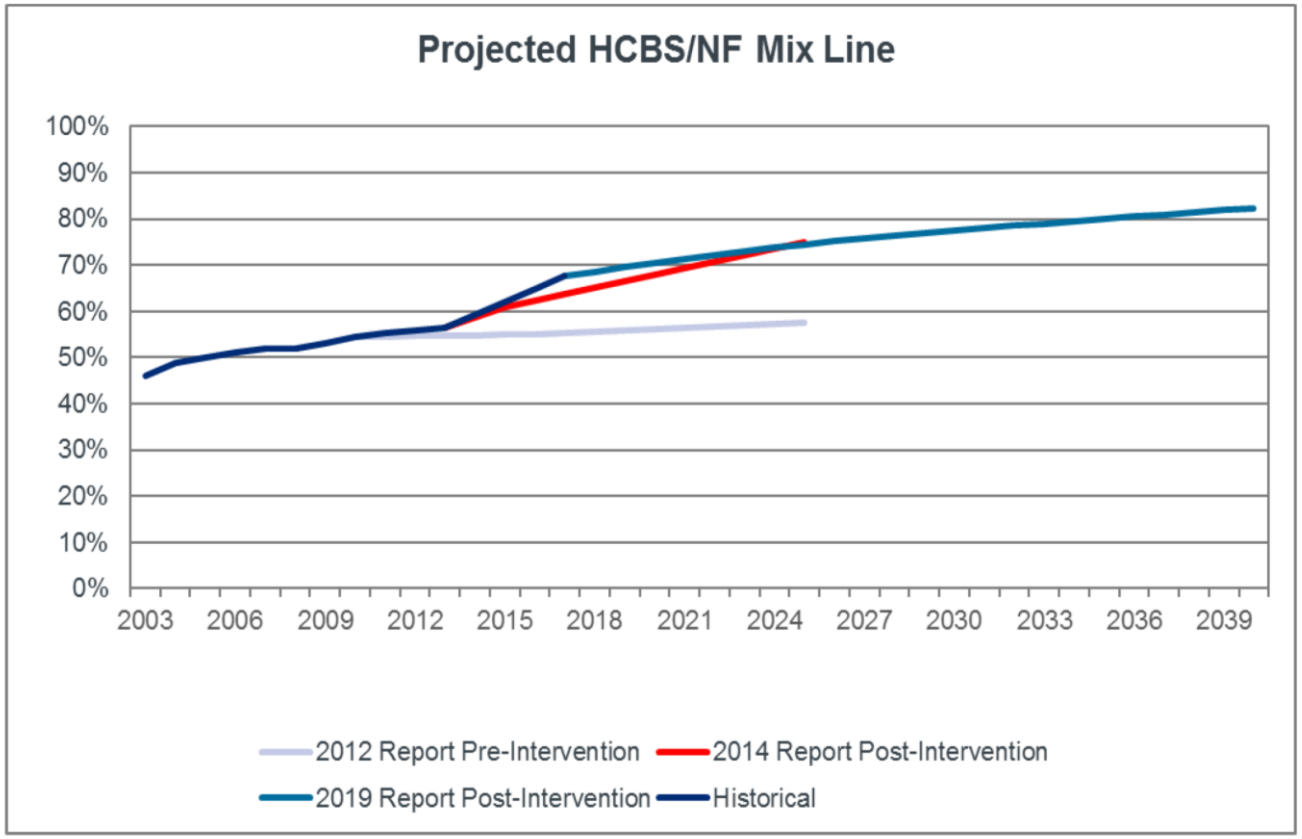
Appendix B
Money Follows the Person Detail

Money Follows the Person Benchmarks

	2007	2019	✓
TRANSITION PEOPLE FROM INSTITUTIONS	0	5956	✓
INCREASE % FUNDING TO COMMUNITY	33%	53%	✓
INCREASE % OF LTSS MEMBERS IN COMMUNITY	52%	64%	✓
INCREASE % OF HOSPITAL DISCHARGES TO COMMUNITY	47%	58%	✓
INCREASE PROBABILITY OF DISCHARGE WITHIN 6 MONTHS	27%	38%	✓

5,956 People Transitioned to Community through 2019





Strategic LTSS rebalancing initiatives have modified the expected trend of where LTSS participants will receive services by 2040. Current projections indicate that by 2040 over 80% of all LTSS participants will receive services in the community by as opposed to in a nursing home.